

**Maternal and Child
Health Services Title V
Block Grant**

Missouri

**FY 2023 Application/
FY 2021 Annual Report**

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I. General Requirements

I.A. Letter of Transmittal



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August 8, 2022

Christopher Dykton, MA, Acting Director
Division of State and Community Health
Maternal and Child Health Bureau
Health Resources & Services Administration
U.S. Department of Health and Human Services (DHHS)
5600 Fishers Lane, 18N100A
Rockville, MD 20857

Dear Mr. Dykton:

I am pleased to submit Missouri's Department of Health and Senior Services Title V Maternal and Child Health Block Grant FFY 2023 Application and FFY 2021 Annual Report. The application and report have been developed in conformance with the Guidance and Forms for the Title V Application/Annual Report (OMB NO: 0915-0172, expiration January 31, 2024) and are being submitted through the HRSA Electronic Handbook (EHB) and Title V Information System (TVIS) web-based reporting systems.

Title V MCH Block Grant funds assure the provision of essential maternal and child health services in Missouri, and we look forward to continued partnership to improve the health of women and infants, children and adolescents, and children with special health care needs.

If you have any questions regarding any part of Missouri's annual application and report, please contact me at (573) 751-6435 or Martha.Smith@health.mo.gov.

Sincerely,

A handwritten signature in blue ink that reads "Martha Smith".

Martha J. Smith, MSN, RN
MCH/Title V Director

Enclosures

www.health.mo.gov

Healthy Missourians for life.

The Missouri Department of Health and Senior Services will be the leader in promoting, protecting and partnering for health.

AN EQUAL OPPORTUNITY / AFFIRMATIVE ACTION EMPLOYER: Services provided on a nondiscriminatory basis.

I.B. Face Sheet

The Face Sheet (Form SF424) is submitted electronically in the HRSA Electronic Handbooks (EHBs).

I.C. Assurances and Certifications

The State certifies assurances and certifications, as specified in Appendix F of the 2021 Title V Application/Annual Report Guidance, are maintained on file in the States' MCH program central office, and will be able to provide them at HRSA's request.

I.D. Table of Contents

This report follows the outline of the Table of Contents provided in the *"Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms,"* OMB NO: 0915-0172; Expires: January 31, 2024.

II. Logic Model

Please refer to figure 4 in the "Title V Maternal and Child Health Services Block Grant To States Program Guidance and Forms," OMB No: 0915-0172; Expires: January 31, 2024.

III. Components of the Application/Annual Report

III.A. Executive Summary

III.A.1. Program Overview

The Title V MCH Program in Missouri is managed by the Department of Health and Senior Services (DHSS), Division of Community and Public Health (DCPH). Martha J. Smith, MSN, RN, is the Maternal Child Health (MCH) Director and Lisa Crandall, BSW, is the Title V Children with Special Health Care Needs (CSHCN) Director. The Title V MCH Services Block Grant application is submitted by the DHSS as the designated state agency for the allocation and administration of these block grant funds. DHSS Title V MCH staff and programming are positioned throughout multiple divisions, sections, and bureaus. DCPH serves as the umbrella agency that facilitates access to numerous MCH-targeted programs and provides a majority of the services to the MCH populations. The capacity of Missouri's Title V MCH Program is large, encompassing DHSS staff, local public health agencies (LPHAs), and numerous private and community partners. It is through these programs, initiatives, and partnerships that a statewide system is supported to meet the needs of the MCH population. In 2020, estimates for Missouri's MCH population, including women of childbearing age, infants, children, and adolescents, was 3,516,166, comprising 57.2% of the state's total population. This included 2,379,451 women of childbearing age (15-44), 1,525,142 infants, children, and adolescents (<1 to 19), 288,780 of which were CYSHCN in the 2019-2020 period.

Based on the Five Year Needs Assessment completed in the spring of 2020, the Missouri Title V MCH Program identified the following FY2021-2025 state priorities and developed strategies / action plans to address these needs:

1. Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.
2. Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
3. Reduce obesity among children and adolescents.
4. Reduce intentional and unintentional injuries among children and adolescents.
5. Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
6. Enhance access to oral health care services for children.
7. Promote Protective Factors for youth and families.
8. Address Social Determinants of Health inequities.

Five National Performance Measures (NPMs) and three State Performance Measures (SPMs) were chosen to align with the priority needs and are discussed below by population domain. Overall, Missouri retained six performance measures from the previous cycle and added two new measures. Progress will be monitored by tracking these performance measures. The needs assessment also identified two overarching principles to be applied across all priorities, performance measures, and strategies. These are to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities.

Title V MCH resources are assigned and program activities are implemented to specifically address the identified priorities. Both budgeted dollars and expenditures are categorized and tracked by population served and across the three service levels in the MCH Pyramid: direct health care services, enabling services, and public health services and systems. Both State and Federal MCH funding help sustain the following programming:

- Community Health Services (injury prevention, adolescent and school health)
- Environmental Health (childhood lead poisoning prevention)
- Epidemiology (vital statistics, analytics, surveillance systems)
- Healthy Children and Families (home visiting, newborn health, TEL-LINK, safe cribs, MCH WarmLine, MCH Navigators)
- Genetics (newborn screening)
- Early Childhood (developmental monitoring, child care health consultation, inclusion services, parent advisory council (PAC))
- Oral Health (preventive services, community outreach)
- Special Health Care Needs (family partnership, care coordination, assistive technology)
- Women's Health (MCH services, infant & maternal mortality, maternal substance use and mental health, health services for incarcerated women)
- Nutrition & physical activity (breastfeeding, obesity prevention)
- Crosscutting (immunizations, communicable disease prevention, health equity)

Women/Maternal Health

Priority: Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.

NPM: Percent of women, ages 18 through 44, with a preventive medical visit in the past year

The health and wellbeing of the mother before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are more likely to experience better health postnatally and across the life span. According to data from the 2020 Behavioral Risk Factor Surveillance System (BRFSS), 72.5% of Missouri women between 18-44 years of age reported having a preventive health care visit within the past year. This was higher than the 2020 national prevalence of 71.3%. In Missouri, a higher percentage of insured women (77.7%) compared to uninsured women (49.5%) received a preventive visit in 2020. The Missouri Title V MCH Program funds efforts to improve access to preventive health care for women, including: TEL-LINK which provides referrals to care for women of childbearing age and their families; the Newborn Health Program which partners with community providers to educate the MCH population on health resources (including preventive care); the Home Visiting Program which facilitates enrollment in MO HealthNet and/or ACA marketplace insurance programs for participants; and MCH contracts with the LPHAs to build community-based systems and expand the resources those systems can use to respond to priority MCH issues, including providing and assuring mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services.

Perinatal/Infant Health

Priority: Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

NPM: A) Percent of infants placed to sleep on their backs.

B) Percent of infants placed to sleep on a separate approved sleep surface.

C) Percent of infants placed to sleep without soft objects or loose bedding.

Deaths due to suffocation, congenital anomalies, and Sudden Infant Death Syndrome (SIDS) are the most significant single causes of postneonatal death. Missouri's rate of infant death related to, SIDS, respiratory distress of the newborn and external causes of mortality in 2020 was over one and half times greater than the national rate (82.1 per 100,000 live births US vs 139.6 per 100,000 live births MO). Mothers with less education, lower household income, who are African-American, or who live in rural counties, are significantly less likely to follow safe sleep recommendations. Safe sleep continues to be a priority for Missouri's Title V MCH Program, which is a primary resource for the Safe Cribs for Missouri Program, providing safe sleep education and free cribs to eligible families.

Title V MCH Home Visiting Program participants also receive intensive education on safe sleep for their infants. Title V MCH provides supplemental funds to support operations of the PRAMS survey, which monitors safe sleep practices in the state, and supports printing and distribution of the *Pregnancy and Beyond* book, which includes information on safe sleep and infant care. The MCH Services Program contracts with LPHAs to promote safe sleep practices.

Child Health

Priority: Reduce obesity among children and adolescents.

NPM: Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day.

Priority: Enhance access to oral health care services for children.

SPM: Percent of children, ages 1 through 17, who had a preventive dental visit in the past year.

In Missouri, 17% of WIC-enrolled two-to-four year olds were overweight, and an additional 14% were obese. Among older children, aged 10-17, 11.7% of Missouri youths were overweight and 16.9% were obese in 2019-2020. Overweight and obesity were more frequent among 10-13 year olds than among high-school-aged youth. Physical activity levels decline as children get older; while 31.2% of 6-11 year-old children were physically active every day, only 17.6% of 12-17 year-olds were.

High levels of physical activity in early childhood are predictors of continued physical activities as children age into young adulthood, underscoring the importance of establishing healthy physical habits in youth. The School Health Program supports school nurses to engage with students and families in addressing overweight/obesity in children. The MCH Services Program contracts with LPHAs to promote physical activity and prevent and reduce obesity among children and adolescents, and the Building Communities for Better Health LPHA contract implements policy and environmental changes that increase opportunities for children to engage in physical activity across multiple settings.

According to National Survey of Children's Health (NSCH) 2019-2020 data, 77.5% of children ages 1-17 years old nationally had a preventive dental visit in the last year. This was a greater percentage than in Missouri (72.5%). A lower percentage of Missouri children age 1-5 years old (49.6%) had a preventive dental visit than their national counterparts (57.9%). This age group also had a lower percentage than Missouri children age 6-11 years old (82.2%) and 12-17 years old (81.7%). 14.8% of Missouri children age 6-11 years had some degree of tooth decay. Title V MCH supports the Office of Dental Health, which promotes cavity prevention and oral health to schoolchildren through literature and programs including providing fluoride varnish at schools statewide.

Adolescent Health

Priority: Reduce intentional and unintentional injuries among children and adolescents.

NPM: Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Priority: Promote Protective Factors for youth and families.

SPM: Suicide & self-harm rate among youth ages 10 through 19.

Intentional and unintentional injury continue to be the leading cause of preventable death and hospitalization among Missouri's children. Missouri continues to report higher rates of injury related death and hospitalization than the national average. In 2020, the leading cause of death for youths aged 10-19 was unintentional injuries. Suicide among Missouri adolescents between the ages of 10-19 is the second leading cause of death for this age group (6.8 per 100,000). In 2020, 53 Missourians aged 10-19 died of suicide, making up approximately 5% of all suicides that year. Improving resiliency and mental health among children and youth of all ages will impact suicide and risk-

taking behavior. Safe Kids Coalitions in Missouri work to provide unintentional injury prevention services to children aged 0-19 years, including addressing teen driver safety. The Adolescent Health Program (AHP) focuses on Social-Emotional Learning, and the Injury Prevention Program, in partnership with the AHP, provides a Mental Health Crisis Toolkit for families with youth experiencing a mental health crisis. The MCH Services Program contracts with LPHAs to prevent intentional and unintentional injuries, prevent child abuse and neglect, and promote motor vehicle, water, bicycle, and other general safety among children and adolescents. LPHAs also promote protective factors for youth and families to prevent adolescent suicide and self-harm.

Children and Youth with Special Health Care Needs (CYSHCN)

Priority: Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.

NPM: Percent of children with and without special health care needs, ages 0 through 17, who have a medical home.

In 2019-2020, 51.9% of Missouri CYSHCN received care through a system that met medical home criteria, a rate greater than that of children and youth without a special health care need (48.5%). Among CYSHCN in Missouri, 47.5% of those with more complex health needs received care that met medical home criteria. Data from the 2019-2020 NSCH showed, among children without special health care needs nationally, 47.9% received care through a medical home, compared with 48.5% in Missouri. This rate is below the HP2030 target of 53.6%. The Bureau of SHCN provides targeted education to enrolling families on the importance of a medical home. Additionally, Title V MCH Programs promote health insurance coverage to improve the likelihood that all children will have a medical home and services to address their needs.

Cross-Cutting/Systems Building

Priority: Address Social Determinants of Health inequities.

SPM: Percent of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Social Justice trainings.

Qualitative and quantitative data indicate that Missouri continues to experience areas of concern, particularly surrounding outcome disparities in maternal and child health. These include racial disparities, economic disparities, and geographic disparities. Title V MCH core team members identify workforce development training on MCH fundamentals, health equity, cultural competence, and social justice to provide foundational skills in the field of maternal and child health. Activities to address the social determinants of health inequities include reviewing training resources, such as the MCH Navigator trainings and MCH Leadership Competencies, establishing core training requirements for internal Title V MCH funded programs/staff and external contractors, and ongoing development of a MCH Training Plan.

III.A.2. How Federal Title V Funds Complement State-Supported MCH Efforts

Federal Title V funds provide backbone funding for approximately 125 key staff positions in MCH programs across the Department of Health and Senior Services and the Office of Childhood in the Department of Elementary and Secondary Education. This includes staff who serve children and youth with special health care needs (CYSHCN), such as the Family Partners; epidemiological staff who analyze data to identify priority health needs of the maternal/child population; and staff who focus on women's, newborn, children's, and/or adolescent's health. Staff also provide technical assistance to community partners, such as Safe Kids coalitions and the 115 Local Public Health Agencies (LPHAs). Contract funding to LPHAs comprises almost thirty percent of federal funds to help build community-based systems and expand the resources those systems can use to respond to priority maternal child health issues. The bulk of remaining contract funds are dispersed for home visiting, service coordination for CYSHCN, early childhood, and dental health contracts. The majority of state match supports newborn screening testing by the State Public Health Lab, newborn screening follow-up, and direct care for CYSHCN. State funds also support women's health services for incarcerated women and the Sexual Assault Forensic Examination – Child Abuse Resource and Education program. Federal Title V funds allow Missouri to coordinate public health services provided to the maternal child population by working across multiple state programs, engaging community partners and families, and collaborating with public health stakeholders throughout the state to address both ongoing and emerging issues.

III.A.3. MCH Success Story

The Family Partnership Program in the Division of Senior and Disability Services (DSDS) Bureau of Special Health Care Needs (SHCN) strives to enhance the lives of children and families impacted by special health care needs by reassuring families that they are not alone and providing resources and information to empower families to advocate for the best health care and quality of life for their child. The Southwest Family Partner serves as a family advocate for the Pediatric Palliative Care (PPC) Task Force through the National Coalition for Hospice and Palliative Care, also serving on the Needs Assessment work group, which includes professionals as well as families who have gone through the process of losing a child. The Task Force focuses on identifying priorities, setting strategies, and coordinating with organizations to route resources, and the purpose of the work group is to make sure families have access to quality PPC and hospice services no matter where they live. Serving on this work group allowed the Family Partner access to resources to help families locate PPC providers in Missouri, better identify needs and respond to requests of individual families, direct families to palliative care teams and hospice providers in their area, and walk through the process of what to expect and the decisions that will need to be made by the family based on their personal requests. Making these important decisions ahead of time gives the family more time to spend with their child, as less time is required away from their child during the time when they are in the process of telling their child good-bye.

While the COVID-19 pandemic resulted in many negative impacts on the lives of mothers, children and families, the Family Partnership Program continued to positively impact children and youth with special health care needs and their families. The shift to virtual engagement options allowed a greater geographic reach, especially for those living in rural Missouri. The Southeast Family Partner attended approximately 30 virtual webinars and trainings on various topics such as social determinants of health, medical home, and COVID-19 specific topics, which helped prepare her for a major career success. The Family Partner received a referral for a mother who needed a tracheostomy tube for her son who was on full life support. The tubes had been on back order for over four months due to nationwide shortages, and the only tracheostomy tube remaining was the one the child was currently using. They were also out of other supplies such as ties and gauze. The Family Partner had multiple conversations with the mom, who had exhausted all available resources. The Family Partner was able to utilize skills acquired as a mother whose son used to have a tracheostomy tube and use a ventilator and from the virtual trainings she had attended throughout the year to provide compassion and emotional support to the mom. She put the mom in contact with a company that was able to meet all of the supply needs within two days.

Four Family Partner positions and Missouri's Family Partnership Program, including the annual Family Partnership Parent and Caregiver Retreat, are supported by Title V MCH Block Grant funding. The success of the Family Partnership Program and Family Partners in building a network of support for families of children and youth with special health care needs demonstrates the value of the partnership between Title V MCH and the Family Partnership and is an example of Missouri's cross-cutting efforts to build family-centered, community-based systems of coordinated care for children and youth with special health care needs.

III.B. Overview of the State

Geography

Missouri is comprised of 115 counties (114 counties and one independent city, St. Louis), covering an area of approximately 69,707 square miles, and ranks 21st in size among all states in the nation.¹ The state is centrally located in the heartland of the United States and shares borders with Arkansas, Kansas, Kentucky, Illinois, Iowa, Nebraska, Oklahoma, and Tennessee. The two largest rivers in the state are the Mississippi, which marks the eastern border of the state, and the Missouri, which flows across the middle of the state. Two large metro areas, Kansas City and St. Louis, are located on the western and eastern borders respectively, and are connected by the "I-70 Corridor."

Demography/Population Density

The 2020 U.S. Census population estimate for Missouri was 6,151,548 residents.² From 2010 to 2020, the state's population increased by 2.6%, including a 2.8% increase for males and a 2.5% increase for females. Missouri was ranked 29th among the 50 states and the District of Columbia for population density with a population density of 89.7 people per square mile in 2021.³

The Missouri population has a noteworthy distribution pattern for its urban compared to rural areas. Missouri is a largely rural state, with 16 urban counties and 99 rural counties^[1]. The City of St. Louis and 15 other counties are considered urban areas. Missouri has six other cities designated as Metropolitan Statistical Areas (MSAs) by the Census Bureau, listed in order of size: Springfield, Columbia, Joplin, Jefferson City, St. Joseph and Cape Girardeau. About 55% of Missouri's population falls within the Metropolitan Statistical Area (MSA) of its two major cities, St. Louis and Kansas City. The St. Louis MSA accounts for 35% of the state's population while the Kansas City MSA contributes almost 21%. Of Missouri's more than 6 million residents, roughly 2,063,000 (34%) live in one of the 99 rural counties.

The largest urban counties by population are St. Louis County (991,163) and Jackson County (709,692). The greatest population density was in St. Louis City with 4,713.99 people per square mile. The lowest population density was in Worth County with 7.4 people per square mile. The largest county in the state by area was Texas County, with an area of 1,179 square miles, and a population density of 21.3 persons per square mile. In total, 47 of Missouri's counties had a population density below 25 persons per square mile.⁴

Age

The estimated median age of Missourians for 2016 to 2020 was 38.7 years old.⁵ For 2020, nearly 22.3% of the state's population (1,371,429) was less than 18 years old, and 17.7% of the population (1,089,714) was age 65 or older.² Missouri's MCH population including women of childbearing age (15-44), infants, children, and adolescents (under 1-19) was 3,516,166.² This accounted for more than half (57.2%) of the state's roughly 6.15 million population. Among this MCH population, 2,379,451 were women of childbearing age (15-44 years), 69,277 infants (under 1) and 1,455,865 children and adolescents (ages 1-19 years).² There was an estimated 288,780 children with special health care needs for the 2019-2020 time period.⁶ In 2020, there were 69,277 Missouri resident live births, of which, 16.4% were African-American and 77.4% were White.⁷ Hispanic births in Missouri increased by less than 1%, from 2010 to 2020 (4,334 and 4,469 respectively).⁷

Diversity/Language

Missouri residents are predominantly White (84%) with a significant African-American (12.6%) population and smaller Asian/Pacific Islander (2.6%) and American Indian (0.75%) resident populations.² For 2020, the top three jurisdictions for proportion of population that is Black or African American alone or in combination are St. Louis City

(45.4%), Pemiscot County (29.8%), and St. Louis County (26.3%).⁸ The Hispanic or Latino population comprises 4.9% of Missouri's population.⁸ Population growth for Hispanics in Missouri was 42.6% from 2010 to 2020,⁸ compared to 23% growth for Hispanics or Latinos nationally.⁹

The U.S. Census Bureau, via the American Community survey, provides 2016-2020 5-year estimate data, suggesting the degree of diversity in Missouri. The 5-year estimate of native-born United States citizens comprising the Missouri population was 5,867,824 (95.8%).¹⁰ Furthermore, ACS data indicate 4.2% of the Missouri population was foreign born with an estimated population size of 256,336 for 2016-2020.¹⁰ Of the residents that were not born in the United States, 39.8% were from Asia, 28.6% from Latin America, 18.4% came from Europe, 9.7% came from Africa, and 3.6% from other regions of the world.¹¹ Furthermore, 361,104 (6.3%) Missourians aged five and above spoke a language other than English at home. Of that group, 125,479 persons spoke English less than 'very well', which was 2.2% of the population 5 years and older. An estimated 149,698 (2.6%) Missourians 5 years and older spoke Spanish at home.¹² The Missouri Department of Health and Senior Services contracts with a vendor to translate program materials and health messages in a variety of languages and up to 17 different dialects to reflect the growing diversity of the state population.

Addressing factors related to diversity that lead to adverse maternal-child health outcomes represents an ongoing challenge for public health in the state. Examining data from 2020, the infant mortality rate (age <1 year) for African American babies (11.7 per 1,000) was more than double that of white babies (4.5 per 1,000).¹³ Though minority populations tend to cluster near urban centers, granting better access to health services than many rural non-minorities, are able to secure care is an additional challenge.

Education

The 2016-2020 ACS estimated percentage of Missourians over the age of 25 that were high school graduates or higher was 90.6%.¹⁴ This percentage was higher than the national average of 88.5%.¹⁵ However, the percentage of Missourians in this age grouping that have a bachelor's degree or higher (29.9%), was less than the U.S. average (32.9%).^{14,15}

Economy

Missouri's metropolitan areas make up the largest portion of the state's economy. St. Louis County and Jackson County combined contribute nearly one third of the state's economy in terms of employment, personal income, and population. Regardless of population size, all regions of Missouri contribute to the state's economic resources. Missouri's rural areas are especially important for tourism and agriculture in the state. In 2021, agriculture, forestry, and related industries contributed estimates both in output of \$93.7 billion and generated 456,618 jobs.¹⁶ Missouri's median estimated household income for 2016-2020 was \$57,290, which was \$7,704 less than the national median household income of \$64,994.^{17,18}

Missouri's unemployment rate decreased from 3.9% in November 2021 to 3.4% in April 2022 (preliminary).¹⁹ Due to the COVID-19 pandemic, many industries were forced to furlough and lay-off workers. Data from the Department of Labor and Industrial relations (DOLIR) showed the total number of initial unemployment claims for Missouri in the month of April 2022 to be 18,008, significant decrease from 32,746 in July 2021 and 81,454 in July 2020.^{20,21,22} Workforce development and economic stability were major focuses of Missouri's COVID-19 response. Missouri's receipt of federal grants for responding to COVID-19 has a positive impact on the state's economic recovery and growth. The use of federal resources to surveil and control the spread of COVID-19 was essential in stabilizing Missouri's economy and preventing further economic decline, while grants still being implemented will be essential in bolstering the state's public health and healthcare infrastructure and workforce. These investments in infrastructure and workforce priorities provide not only short term economic benefits but also better prepare Missouri to protect from

potential economic shocks from future health crises.

Poverty

The ACS provides poverty data for the population for whom poverty status was determined. Among this population of Missourians, the estimated percent of those below the poverty level for 2016-2020 (13.0%) was lower compared to the estimated percent (13.7%) for 2015-2019.^{23, 24} Furthermore, Missouri's estimated 2016-2020 poverty rate for children under 18 years old was 17.4%, which was higher than the state overall rate. Nearly 773,000 Missourians were living below poverty and nearly 234,000 of them were children.²³

Food insecurity is an important issue that can affect children and families and may be affected by having poverty-level income. Current Population Survey Food Security Supplement data suggests Missouri's average 2018-2020 household food insecurity rate was 11.5%, which was higher than the national rate of 10.7%.²⁵ Additionally, the 2019 estimated overall child food insecurity rate for Missouri was 14.8%.²⁷ The 2018-2020 very low food security rate for Missouri was reported to be 5.1% compared to 4.1%, nationally.²⁵

Homelessness

The 2021 Annual Homeless Assessment Report (AHAR) to Congress provides estimates of the number of people experiencing homelessness, homeless families with children, and unaccompanied homeless youth on any given night in January 2021. Overall, a total of 6,438 Missourians, 1,720 families with children and 338 unaccompanied youth were reported to experience homelessness on any given night in January 2021.²⁸

Environment

Lead mining and smelting has been an important part of Missouri's history since the early 1700's. Missouri has been the dominant lead-producing state in the nation since 1907. Though there are many possible sources of lead exposure, the most common sources of lead poisoning in MO are lead dust, lead in soil, and peeling, chipping or cracking lead-based paint. The highest risk of lead exposure for children, however, comes from homes built before 1950, when most paint contained a high percentage of lead. Lead-based paint was banned from residential use nationwide in 1978. Any home built before 1978 may contain leaded paint. About 18.55% of existing housing stock in MO was built before 1950, and 55.38% was built before 1980.

The MO Childhood Lead Poisoning Prevention Program (CLPPP) was established in 1993. The program's mission is to assure the children of MO a safe and healthy environment through primary prevention, detection, surveillance, and case management for lead exposures. There is no "safe" level of lead in the body. Inhalation or ingestion of even very small amounts of lead causes neurotoxic health effects, and can affect nearly every other body system. Very high blood lead levels may cause death. Passed in 2001, 701.340 RSMo required the promulgation of rules and regulations to establish a statewide lead screening plan. The rules and regulations define criteria for establishing blood lead testing and reporting requirements and for medical and environmental case management follow-up and treatment procedures.

The annual percent of Missouri's children younger than six years old tested for lead exposure decreased from the reported 20.4% for 2010 to around an estimated 14% for 2021.²⁹ Among this same age group of children, the percentage found to have blood lead levels of 10 µg/dL or greater has declined from 0.97% in 2010 to 0.55% in 2021.²⁹ Children who tested with blood lead levels greater than or equal to 5 µg/dL, the 2012 reference value recommended by the CDC, was 6.5% in 2010. Children who tested with blood levels greater than or equal to 3.5 µg/dL, the updated CDC-recommended reference value, was reported to be 4.75% for 2021.²⁹

Transportation

In 2020, Missouri had the seventh largest highway system in the nation.³⁰ The transportation infrastructure has three key measures: railroad mileage, waterway mileage, and airports. The Missouri highway system is comprised of nearly 34,000 miles of highways and more than 10,000 bridges. Additionally, the county road system adds 97,000 miles and nearly 14,000 additional bridges. The extent of this infrastructure gives Missouri residents and businesses efficient accessibility to major markets for distribution needs and telecommunication. However, in both urban and rural areas access to public transportation can be cumbersome.

There was a 23% increase in vehicle fatalities from 2010 to 2020.³¹ 50% of motor vehicle crash deaths occurred in rural areas in 2020, and lack of seat belt use, distracted driving and driving too fast for the conditions continue to be common denominators in fatal crashes.³² Between 2010 and 2020, 9,877 people were killed in motor vehicle accidents in Missouri, an average of about 898 fatalities per year.^{31,33} For the first time since 2006, Missouri's 2021 traffic fatality total surpassed 1,000. According to preliminary data, 1,017 people were killed in Missouri traffic crashes in 2021, a 3% increase over 2020, marking the second straight year of growing fatality totals after nearly a decade of steady decline.

The MO Department of Transportation works with safety advocates across the state with a goal of 700 or fewer fatalities. The reported safety belt usage rate in Missouri (88.0%) in 2020 was below the national average of 90.4% for the same year.³⁴ Missouri has secondary seat belt law. There is primary enforcement of the seat belt requirement for children ages 8 to 15 years and secondary law for those ages 16 and above in the front passenger seat.³⁵

Health Infrastructure

There are five predominant schools that train new physicians in Missouri: Kansas City University of Medicine and Biosciences, University of Missouri – Kansas City, University of Missouri - Columbia, Saint Louis University, and Washington University. Missouri Professional Registration Directories include 3,463 Osteopathic Physicians, and 25,388 Medical Physicians and Surgeons.^{36,37} Of these Osteopathic Physicians, Medical Physicians, and Surgeons, there are 922 Obstetrician/ Gynecologists and 16 specializing in Obstetric/Gynecologic surgery.^{36,37} Additionally, there are 2,066 physicians certified in pediatrics and 621 specialized pediatricians (e.g. pediatric pulmonology, pediatric emergency medicine, pediatric cardiology, etc.).^{36,37}

As of June 1, 2022, there were 170 hospital facilities in the state of Missouri spread across 70 counties/jurisdiction.³⁸ The majority of hospitals are located in urban counties. There are also 49 total hospitals with psychiatric beds³⁹ and 29 trauma facilities in Missouri.⁴⁰ There were 842 licensed pediatric beds in Missouri and 893 licensed NICU beds.^{41,42} In addition, there are four VA Medical Centers and one VA Health Care System in the state of Missouri, not inclusive of 27 community based outpatient clinics, 1 outpatient clinic, and five veterans centers.⁴³ There are 343 Rural Health Clinics (RHC), which must be located in a non-urban area and in a federally designated or certified shortage area, and 28 Federally Qualified Health Centers (FQHC; 13 in rural areas only, 7 in urban areas only, 8 with sites in rural and urban areas, and 314 service delivery sites), which are community-based and patient driven care centers designed to help people with limited access to care.⁴⁴

Health Indicators

Missouri's three primary strengths, as identified in America's Health Rankings 2021 Annual Report published by the United Health Foundation, were its low prevalence of high-risk HIV behaviors, low percentage of severe housing problems, and high school graduation rate.⁴⁵ Of note, nearly 90% of students graduated from high school. Though Missouri ranks 35th for smoking, data indicate a 14% decrease in smoking among adults from 2017 (20.8%) to 2020 (17.8%). Severe housing problems (determined based on the percentage of occupied housing units) decreased 10% from between 2009-2013 and 2014-2018. The 2021

Annual Report also identified notable challenges for Missouri, including poor exercise, avoiding care due to cost, and frequent physical distress. Approximately 12% of adults avoided care due to cost, 26.7% were physically inactive, and 11.4% of adults experienced frequent physical distress. In addition to physical distress, mental distress increasingly presents a challenge for Missourians, with a 31% increase in frequent mental distress among Missouri adults from 2014 to 2020. Nationally, Missouri ranked 36th for low birthweight and 35th for low birthweight racial disparity.⁴⁵

Health Insurance Coverage

Overall, Current Population Survey estimates indicate an increase in percentage of uninsured Missourians from 7.7% in 2016 to 9.7% in 2020.^{46,47} Missouri's estimated uninsured percentage for 2020 is higher than the 8.6% national estimate for the same year.⁴⁸ Missouri's estimated percent of children under the age of 19 without public or private health insurance for 2019 (6.5%) increased from 2018 (5.7%) and was higher than the national level for 2019 (5.7). An estimated 14.8% of Missouri women (ages 19-44) were without public or private health insurance in 2019 compared to 13.4% for 2018.⁵⁰ The estimated percentage for 2019 was higher than the national level for the same year (12.9%).⁵⁰

The Uninsured Women's Health Services Program provides MO HealthNet coverage for women's health services to uninsured women ages 18 up to but not including age 56 whose family's modified adjusted gross income (MAGI) does not exceed 201% of the FPL for their household size. Covered Women's health services include: approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; family planning, counseling, education on various methods of birth control; and drugs, supplies, or devices related to the women's health services described above, when they are prescribed by a physician or advanced practice nurse.

Medicaid and CHIP provide no-cost or low-cost health coverage for eligible children in Missouri. Using CHIP funding, states can opt to provide coverage for pregnant women and/or services through the "unborn child" coverage option, and Missouri provides coverage up to 300% of the FPL through the CHIP for pregnant women option and unborn child options. Medicaid spending for state fiscal year 2020 was around \$10.8 billion in Missouri⁵¹, and 52% of Missouri Medicaid/MO HealthNet funds came from the federal government.⁵² Non-disabled adults with children qualify for Medicaid if their income is below 21% of the FPL, meaning a family of four must earn less than \$5,550 a year. Medicaid and CHIP enrollment in Missouri was 1,064,287 in May 2021, and 87.1% of all uninsured eligible children in Missouri participate in Medicaid/CHIP. Children represent the largest demographic group served by Missouri Medicaid; 61% of all MO HealthNet enrollees are under the age of 19.⁵¹

The MO HealthNet for kids (Medicaid) program provides health insurance coverage for children under age 19 whose net family income does not exceed 196% of the FPL for children under age one, and 148% of the FPL for children ages 1-18. In state (S)FY 2020, MO HealthNet covered 533,202 low-income children.⁵¹ In SFY 2020, the MO HealthNet For Kids Program covered 497,104 low-income Missouri children, representing 57% of all MO HealthNet beneficiaries. Overall, Medicaid covered 37% of Missouri's children and paid for 39% of all births in the state for 2020.⁵¹ Children represent the largest demographic group served by MO HealthNet, with 61% of all Medicaid enrollees being age 18 or younger.⁵¹

Using the State Children's Health Insurance Program (SCHIP) funds, Missouri expanded its existing Medicaid program for low-income children in 1998. This SCHIP expansion extended health coverage to low-income children with family income up to 300% of FPL.⁵¹ The SCHIP program provides the same health services as those covered under Medicaid, except that children covered by SCHIP are not eligible for non-emergency medical transportation. Based on an income scale, some individuals covered under Missouri's SCHIP program must pay premiums. For families of six or fewer, premiums paid per family per month range from \$15 to \$324.⁵¹ In 2020, monthly CHIP enrollment ranged from 98,828 to 108,559 participants in Missouri.⁵³

The MO HealthNet for pregnant women program offers Medicaid coverage to pregnant women whose family incomes are up to 201% FPL. This program includes coverage up to 60-days postpartum even with subsequent increases in family income. In SFY 2020, an average of 23,363 women received benefits under the MO HealthNet for Pregnant Women Program.⁵¹

Statewide-Managed Care

The MO HealthNet managed care system (formerly known as MC+) started in 1995 when Missouri DSS first contracted with managed care plans in an effort to improve the accessibility and quality of health care services for Missouri's Medicaid populations, while improving predictability of the costs associated with providing care. Missouri expanded Medicaid managed care in 2017 to include all 114 counties and the city of St. Louis for children, families, and pregnant women. The MO HealthNet Managed Care program operates statewide to provide health care services to enrollees through contracts between the Department of Social Services' MO HealthNet Division (MHD) and Managed Care health plans. These include Home State Health Plan, Healthy Blue, Show Me Healthy Kids, and United Healthcare. Each Managed Care health plan has a network of doctors, hospitals and other providers across the state of MO that coordinate care to help individuals and families stay healthy.

In SFY 2020, there were 97,302 low-income custodial parents and pregnant women and 533,202 low-income children covered by MO HealthNet.⁵³ The goal of the MO HealthNet Managed Care program is to improve health care quality and access to needed services, as well as increase the efficiency of health care delivery for covered low-income custodial parents, pregnant women, and children while controlling the program's cost. All MO HealthNet recipients must enroll in a managed care health plan if they fit into one of the following eligibility categories:

- Parents/caretakers, children, pregnant women, and refugees;
- Other MO HealthNet children who are in the care and custody of the state and receive adoption subsidy assistance; and
- CHIP children.

Missourians who are aged, blind or disabled, including those Missourians with developmental disabilities served through the Missouri Department of Mental Health, will not be included in the MO HealthNet Managed Care program. They will continue to receive services through the traditional MO HealthNet Fee-for-Service (FFS) program. Certain participants (including a child with special health care needs) may also opt out of the managed care program and choose the FFS program.

Medicaid Expansion

Missouri experienced a long and complicated road to Medicaid expansion. In 2020, Missouri voters approved an amendment to the Missouri Constitution to expand Medicaid eligibility to persons 19 to 64 years old with an income level at or below 133% of the FPL (plus five percent of the applicable family size), effectively expanding Medicaid to those with incomes at or below 138% of the FPL as set forth in the Affordable Care Act. In 2022, that will amount to approximately \$18,754 for a single individual, and \$38,295 for a household of four (children were already eligible for Medicaid at higher income levels). Medicaid eligibility was previously set in state statute, but the amendment added Medicaid Expansion to Missouri's constitution with an effective date of July 1, 2021. However, following the passage of this amendment, the MO legislature did not include funding for Medicaid Expansion in the SFY 2022 state budget, and Governor Parson subsequently announced the state would not implement expansion because the ballot measure did not include a revenue source and the MO legislature did not provide sufficient appropriations for expansion in the state budget. Following this announcement, individuals who would be eligible for expansion coverage under the Missouri Constitution filed a lawsuit against the state. The Missouri Supreme Court ruled the initiated amendment

was valid under the state constitution, and the legislature's existing budget appropriation authorized the state to implement expansion coverage.

The amendment prohibits any additional burdens or restrictions on eligibility for the expansion population and requires state agencies to take all actions necessary to maximize federal financial participation in funding medical assistance under Medicaid Expansion. Federal law requires states to fund a portion of the program in order to receive federal funding (state match). This amendment does not provide new state funding or specify existing funding sources for the required state match. The federal government is paying 90% of the cost of Medicaid expansion in Missouri, just as they do in other states that have expanded Medicaid. However, since Missouri's expanded eligibility rules took effect after the American Rescue Plan was enacted, the state is also receiving an additional 5 percentage points above the regular federal matching rate for the next two years for the traditional (non-expansion) Medicaid population, amounting to \$968 million in additional federal funding over two years. The state's estimated share of the cost of Medicaid expansion for state fiscal year 2022 was approximately \$156 million, and American Rescue Plan funding should offset the state's costs in the short term.

The DSS began accepting applications for coverage in August 2021 and began processing applications after October 1, 2021. Coverage was backdated to July 1, 2021 for eligible applications submitted by November 1, 2021. More than 17,000 people applied for coverage by October 1st. Expansion was expected to result in 275,000 additional Missouri residents becoming eligible for MO HealthNet, but enrollment thus far is lagging behind expectations.

In 2018, Missouri lawmakers passed a provision to add some benefits, such as a year-long Medicaid extension, for low-income mothers with substance use disorder. The DSS contacted the Centers for Medicare and Medicaid Services in February 2022 asking to pause those benefits. State officials cited two main reasons for not moving forward: voter-approved Medicaid expansion was expected to decrease the number of women who could be served under extended postpartum coverage, and lawmakers were considering an expansion of postpartum coverage to allow for full benefits to be provided through the full first year after birth.

Missouri currently provides coverage to low-income mothers during pregnancy and up to 60 days after childbirth. The Missouri Pregnancy Associated Mortality Review Annual Report recommends that the state extend Medicaid coverage to one year after childbirth for all conditions, including medical, mental health and substance use disorder. In an effort to improve maternal health and address racial disparities, the American Rescue Plan Act of 2021 allows states to extend postpartum Medicaid coverage up to a full year after birth. The new option is available to states for five years, starting April 1, 2022. Bills introduced in this year's legislative session sought to authorize the extension of postpartum coverage for a full 12 months after birth. The bills garnered significant bipartisan support and were eventually combined into a bipartisan bill. The bill's fiscal analysis estimated \$4.4 million in state costs for the 2023 budget year, with the federal government subsidizing the rest of the estimated \$12.3 million total cost. Although there seemed to be bipartisan consensus that expansion is necessary for Missouri's mothers, due to threats of a (unrelated) filibuster, the bill did not progress through a vote in the Senate. According to the bill's fiscal analysis, 4,565 women who received Medicaid benefits during pregnancy would likely have qualified for the extended coverage.

Department of Health and Senior Services (DHSS) Priorities

In Missouri, the Title V MCH Program is located within DHSS. Paula Nickelson was appointed March 1, 2022, as the Acting Director of DHSS and is responsible for the management of the Department and the administration of its programs and services. Ms. Nickelson has served within DHSS for more than 22 years and been a leader in several program areas, including maternal-child health, chronic disease prevention, and emergency preparedness and response.

Since 2016, DHSS has been accredited through the Public Health Accreditation Board. The DHSS is, “To be the leader in promoting, protecting and partnering for health’ in order to achieve the vision of ‘Healthy Missourians for life.’” DHSS executes the following foundational responsibilities:

- Providing public health services and supports to all citizens.
- Ensuring regulation of facilities and service providers that deliver care to Missourians.
- Performing oversight of programs and protections for elderly and vulnerable residents.

Premiere DHSS Initiatives

Enhancing and Innovating Health Services for Missouri’s Women and Mothers

2019 legislation enhanced Missouri’s Pregnancy Associated Mortality Review (PAMR) Board implementation of clinical best practices and data-driven solutions to improve maternal health and mortality rates. Grants have been awarded to Missouri as part of the Alliance for Innovation on Maternal Health (AIM) quality improvement initiative to implement proven outcome based national models that improve maternal safety. The Department has also been awarded the Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) grant to identify, review, characterize, and identify prevention opportunities within maternal deaths. DHSS is the first state health department in the nation to launch a Count the Kicks program to enhance education and awareness among expectant mothers of possible safety or health concerns of their unborn child.

Reconnecting Care in Rural Missouri

Beginning with the Governor’s Rural Health Summit in 2018, DHSS has been working to realign resources to address the state’s rural health issues. DHSS is working collaboratively with other public and not-for-profit entities to address Missouri’s rural care provider shortage to attract and retain additional health professionals in underserved areas. DHSS coordinated a robust response to COVID-19 outbreaks in rural Missouri, while also administering grants to address the opioid crisis in rural communities.

Strategic Management Priorities

The State of Missouri Cabinet team developed a management change agenda to improve how Missouri government operates. All 16 Cabinet Departments developed strategic management priorities, and a simple “placemat” summarizes these priorities. These priorities include a set of change initiatives DHSS is pursuing to improve performance and outcomes for the citizens of Missouri. DHSS’ aspiration is to protect health and keep people of Missouri safe. Themes identified to reach this aspiration are public health system building, infant and maternal, health behavior, emerging public health threats preparedness, social determinants of health, and whole person health access. Priority infant and maternal health initiatives include developing enhanced newborn screening and reporting capabilities to enable early public health intervention efforts, maintaining PAMR board engagement and oversight to improve infant and maternal health outcomes, and establishing the MCH Advisory Council to ensure efficient and effective use of grant funding.

Public Health Improvement & Transformation Effort: Making Long-Term Investments to Improve Missouri’s Public Health System

In 2021, the Governor’s Office, in coordination with DHSS, launched a team effort to improve and transform public health in the State of Missouri. State team members, public health experts, and key stakeholders convened to identify improvements, gaps, and needs in public health, and to further discuss how those improvements can fit into transformative public health models and potential funding efforts to ensure strategic and citizen-focused investments and help support and improve the public health system well into the future. DHSS leadership continues to engage with stakeholders to transform the state public health system, with lines of effort focused around Missouri’s Foundational Public Health Services Model (<https://www.healthiermo.org/>).

Office of Childhood: Promotes Effectiveness, Excellence, and Equity for Missouri Children

On January 28, 2021, Governor Parson signed [Executive Order 21-02](#) officially establishing the new Office of Childhood, effective August 28, 2021. The new office is housed at the Department of Elementary and Secondary Education (DESE) and provides a comprehensive approach to early childhood care and education, including all state programs related to child care, home visiting, early learning, and early intervention. The transition to one office streamlines early childhood work across state government and ensures all Missouri children and families have access to more consistent, quality programs and services. The goal is to reduce duplication, improve coordination of services, and create a more effective early childhood system to provide all children in Missouri access to an equitable, improved early childhood care and education system where all children are safe, healthy and successful learners. The Office of Childhood consists of approximately 145 employees, including FTEs, programs and contracts funded in part or whole by Title V MCH.

Missouri State Board of Health and Senior Services

The State Board of Health and Senior Services advises the Department Director in planning for departmental activities and acts in an advisory capacity regarding rules promulgated by the Department of Health and Senior Services. Board members are appointed by the governor to help set the strategic direction for DHSS.

Missouri Women's Health Council

The Missouri Women's Health Council is an advisory board comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the Department Director and reflect the geographic diversity of the state. The Council is charged with informing and advising the Department Director regarding women's health risks, needs and concerns, and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The Council consists of women from a variety of professions, including health care providers, researchers, healthcare administrators, social workers, and CEOs and executive directors of critical social services foundations serving women throughout Missouri. The following policy priorities reflect the shared vision of the Women's Health Council:

1. Improve access to healthcare for women in rural, suburban and urban Missouri, and
2. Ensure safety for Missouri women and their families.

Missouri's Title V MCH Program is involved with many DHSS initiatives and priorities. Title V MCH efforts to provide positive health outcomes for the MCH population align with the DHSS goal to improve the health of all Missourians. The national and state performance measures and strategies identified in the MCH State Action Plan assist in achieving DHSS objectives. The MCH Director and relevant Title V MCH team members participate in the PAMR Board meetings and discussion to reduce maternal mortality. The Title V MCH Program team also works with local public health agencies, the majority of which are located in rural communities, to ensure access to healthcare services for women and children.

Revised Statutes of Missouri (RSMo) Relevant to Title V MCH

Title XII Public Health and Welfare, Chapters 191, 192, and 201 include laws in place to benefit the MCH population. A few examples are listed below.

- §191.323 (1985) gives DHSS the power and duty to prevent and treat genetic disease and birth defects and
- §191.331 (2007) allows infants to be tested for metabolic and genetic diseases. This chapter also addresses prenatal and postnatal care and education for women and children, breastfeeding, and prenatal screening counseling.
- §192.002 (2001) and §192.005 (2018) established DHSS to supervise and manage all public health

functions and programs. The department shall be governed by the provisions of the Omnibus State Reorganization Act of 1974, Appendix B, RSMo, unless otherwise provided in sections 192.005 to 192.014.

- §192.025 DHSS is designated as the official agency of the state to receive federal funds for health purposes.
- §192.067 authorizes DHSS to receive information from patient medical records for the purpose of abstracting data (i.e. PAMR).
- §192.070 (2001) states DHSS shall issue educational literature on the care of the baby and the hygiene of the child including, but not limited to, the importance of routine dental care for children; study the causes of infant mortality and the application of measures for the prevention and suppression of the diseases of infancy and childhood; and inspect the sanitary and hygienic conditions in public school buildings and grounds.
- §192.601 (2013) requires a toll-free telephone number established for the use of parents to access information about health care providers and practitioners who provide health care services under the Title V MCH Services Block Grant, the medical assistance programs, and other relevant health care providers, as required by 42 U.S.C. 705(a)(5)(E).
- §201.010 (2010) gives DHSS the authority to administer children's special health care needs service, a program of service to children who have a physical disability or special health care need and to supervise the administration of the services that are included in this program. The purpose of this service is to develop, extend, and improve services for locating such children, especially in rural areas, and for providing medical, surgical, corrective and other services and care and facilities for diagnosis, hospitalization, and aftercare (§201.030).
- §192.990 (2019) establishes the "Pregnancy-Associated Mortality Review (PAMR) Board" within DHSS to improve data collection and reporting with respect to maternal deaths.

Code of State Regulations (CSR)

- 19 CSR 20-60.010 establishes criteria and procedures for reporting standardized assessments and levels of maternal and neonatal care designations for birthing facilities.

Major Legislative Initiatives

Provided below is a list of bills and legislative decision items with potential impact for Missouri families that were passed during the 102nd General Assembly, 2022 Regular Session, and signed by the Governor:

SB 683 Includes provisions creating the "Correctional Center Nursery Program." The Missouri Department of Corrections is required to establish a nursery within a women's prison by July 2025, allowing infants born to women in prison to stay with their mothers for the first 18 months of life.

SB 718 Modifies provisions relating to higher education, including provisions to: establish the "Dual Credit and Dual Enrollment Scholarship Act", providing qualifying students a scholarship equal to the tuition and fees paid for dual enrollment courses; create the Workforce Diploma Program to help adults obtain a high school diploma; and require public higher education institutions to post the Suicide and Crisis Lifeline number on student ID cards.

SB 775 Modifies several provisions relating to victims of sexual offenses, including: amending the "Justice for Survivors Act" and the "Sexual Assault Survivors' Bill of Rights" to reflect input from healthcare providers and advocates in Missouri, and protects certain identifying information of survivors of sexual assaults.

SBs 681 & 662 Establish the "Get the Lead Out of School Drinking Water Act". Beginning in the 2023-24 school year, each school shall provide drinking water with a lead concentration below five parts per billion (5 ppb). On or before January 1, 2024, each school shall conduct an inventory of all drinking water outlets and outlets used for dispensing water for cooking or cleaning utensils in each school building, develop a plan for testing each outlet, and provide general information on the health effects of lead contamination to employees and parents. Before August 1, 2024, schools shall conduct testing for lead as specified in the bill. Within two weeks after receiving test results, schools shall make all testing results and any remediation plans available on the school's website.

SB 769 Creates provisions establishing four pilot recovery high schools for students in recovery from substance use disorder or substance dependency.

HB 2162 – Modifies provisions related to the Opioid Addiction Treatment and Recovery Fund, allowing additional state departments to access the moneys in the Fund to pay for opioid addiction treatment and prevention services and health care and law enforcement costs related to opioid addiction treatment and prevention. The bill also allows the Department Director to authorize a Missouri licensed physician to issue a standing order for Naltrexone.

HB 1738 & SB 710 Designated April 11th through 17th of each year as "Black Maternal Health Week".

In response to the United States Supreme Court's ruling overturning Roe v. Wade, the governor signed a proclamation and the attorney general issued an opinion restoring state authority to regulate abortion, giving legal effect to Section 188.017, RSMo, and activating the "Right to Life of the Unborn Child Act." Section 188.017, or the "Right to Life of the Unborn Child Act," includes provisions to prohibit doctors from performing abortions unless there is a medical emergency; create criminal liability for any person who knowingly performs or induces a non-medical emergency abortion and subjects his or her professional license to suspension; and protect any woman who receives an illegal abortion from being prosecuted in violation of the Act.

In July 2022, the Governor called for a special legislative session to pass tax relief, including reducing the individual income tax rate, increasing the standard deduction, and exempting the first \$16,000 of income for single filers and \$32,000 for joint filers from state income taxes.

SFY 2023 Budget Wins

Budget increase of \$438,231 to address inflation costs and fund improvements to the Newborn Screening Program.

American Rescue Plan Act (ARPA) Grants:

- COVID-19: \$108,681,193 for COVID-19 response and testing activities such as advanced molecular detection capacity, testing and support for people experiencing homelessness, distributions of vaccines in underserved and underrepresented populations, expanded testing in rural hospitals, and expanded data collection and reporting for travelers; and \$767,004 for the National Initiative to Address COVID-19 Health Disparities, the ELC Enhancing Detection Expansion, and the STD Disease Intervention Specialists grants.
- Workforce Development: \$45,242,682 to expand the public health workforce and infrastructure in the State of Missouri.

\$530,000 to establish a perinatal quality collaborative, implementation of the Alliance for Innovation on Maternal Health bundle, a Neonatal Abstinence Syndrome project, and a safe sleep quality improvement project.

Rape Prevention Education Grant: \$495,000 to provide outreach and education for adolescents to effect change on behaviors of sexual violence.

\$2,500,000 to implement evidence-based strategies and innovative approaches to prevent youth from using tobacco products, eliminate second-hand smoke exposure, and promote tobacco cessation services.

\$800,000 to purchase and distribute naloxone doses to first responders.

\$200,000 for grant programs to provide access to physicians in underserved areas.

Primary Care Resource Initiative for Missouri (PRIMO) Expansion: \$121,250 to increase the health care workforce by recruiting students into health care career paths.

\$600,000 to replace x-ray fluorescent analyzers to benefit the Child Lead Prevention, Environmental Child Care, Waste Management, Superfund, and Brownfields programs.

Justice for Survivors Telehealth Network: \$3,953,820 to provide access to sexual assault nurse examiner consultation services and guidance for medical providers to deliver forensic examination services via telehealth.

\$14,404,834 to expand the Ryan White Program to provide services through local public health agencies and private providers to serve an additional 150 clients living with HIV.

For references, please refer to the References attachment.

[¹] Using the definition described in the Biennial Rural Health report (<https://health.mo.gov/living/families/ruralhealth/pdf/biennial2020.pdf>) which assigns counties as rural or urban primarily based on meeting a population density of greater or less than 150 persons per square mile.

III.C. Needs Assessment

FY 2023 Application/FY 2021 Annual Report Update

Five-Year Needs Assessment Update

Ongoing Needs Assessment Activities

Developments with the Missouri Pregnancy Risk Assessment Monitoring Surveillance System (PRAMS), Missouri Behavioral Risk Factor Surveillance Survey (BRFSS), and the Missouri Pregnancy Associated Mortality Review (PAMR) are significant components of ongoing MCH data collection and analyses. Missouri is also amongst a group of states participating in efforts to monitor emerging threats. These efforts are detailed in the Other MCH Data Capacity Efforts section.

Updates to MCH Data Collection and Analyses

1. Missouri PRAMS collected vaccination data through the COVID-19 vaccine supplement.
2. Missouri PRAMS is currently participating in the Social Determinates of Health supplement.
3. The Missouri Pregnancy Associated Mortality Review (PAMR) completed reviewing 2019 maternal deaths (see [report](#)) and is in the process of initiating review of 2020 maternal deaths.
4. Missouri is participating in the analyses of COVID-19 impact on pregnancy outcomes through the CDC “Surveillance for Emerging Threats to Mothers and Babies” (SET-NET) project.

Stakeholder Engagement

Ongoing MCH stakeholder engagement and input is sought through various opportunities and venues. Collaborative brainstorming and discussion related to the FFY 2021-2025 Title V MCH State Action Plan and other MCH priorities and initiatives for regional and statewide collective impact were facilitated through four virtual stakeholder meetings. Stakeholders participating included DHSS team members, other state agencies, local public health partners, for-profit and not-for-profit community organizations, faith-based organizations, family partners, and community members. Additional information regarding the stakeholder meetings may be found in the Public Input section narrative.

The Title V MCH core team developed a stakeholder survey to solicit further individual and organizational stakeholder input on the State Action Plan, challenges to improving MCH outcomes, emerging MCH issues and needs, and program performance metrics. The survey was disseminated electronically in June 2022, and approximately 170 individuals, representing LPHAs, state agencies, community and faith-based organizations, health care professionals, parents/caregivers of infants, children, adolescents, and/or children and youth with special health care needs (CYSHCN), and adolescents and adolescent/youth leaders, responded to the survey. A major theme emerging from the preliminary analysis is the impact of the COVID-19 pandemic on the ability to effectively deliver services due to either staff turnover or redirection of staff priorities to COVID-19 duties; this significantly impacted access to care for MCH populations. A decrease in the community’s trust in public health systems was also highlighted in survey responses. Other challenges reported include a lack of access to mental health services for adolescents and postpartum women and preventive health care, including oral health services, due either to provider shortages or lack of providers who accept Medicaid insurance. Responses also indicated the impact of lack of access to healthcare services on rural and low-income MCH populations was exacerbated by the COVID-19 pandemic and the increasing cost of living. Recommendations to meet the objectives of the state action plan included extension of Medicaid during the postpartum period to improve maternal mental health and preventive care education through schools, healthcare providers, social media and public service announcements to increase awareness of preventive practices as well as programs and services available at the local and/or state level. Emerging MCH priority needs identified were increases in Sexually Transmitted Infections (STIs) and lack of access

to family planning and sexual education. More in-depth analysis of survey responses will be completed, and findings will be used to strengthen and develop strategies and activities to address the priority needs identified as part of the state action plan and develop plans to address the emerging needs of the MCH population.

MCH Population: Health Status and Needs

Data indicate improvements in health markers among the Missouri MCH population. Specifically, the infant death rate decreased from 6.0 per 1,000 live births in 2019 to 5.7 in 2020. Not only is the 2020 rate 14 percent below the 2010 rate of 6.6, but the 2020 infant death rate also represents a record low Missouri infant mortality rate. Further, the percent low birth weight decreased from a record high of 8.9 in 2019 to 8.7 in 2020. The rate of inadequate prenatal care increased slightly to 21.3 percent in 2020 from 21.1 in 2019. Between 2019 and 2020, teen births continued to decrease, moving from 3,889 to 3,591 births born to mothers under the age of 20. This decrease in teen births is a 54 percent decrease from the 2010 count of 7,739. In addition, short spacing, defined as less than 18 months between births, decreased from 12.5 percent in 2019 to 12.3 percent in 2020. C-sections decreased from 30.1 percent in 2019 to 29.3 percent in 2020. Multiple births decreased from 3.5 percent to 3.4 percent of births. Notably, the rate of mothers smoking during pregnancy decreased to 11.9 percent in 2020 from 12.8 percent in 2019 and 18.9 percent in 2010. Where there have been improvements, it will be important to continue to implement appropriate efforts that will promote further progress.

Conversely, data indicate other areas where health markers among the MCH population are moving in an opposite direction. Specifically, the rate of births to obese (BMI>30) mothers increased to 30.8 percent in 2020 from 30.1 in 2019 and 23.8 in 2010. The rate of out-of-wedlock births increased from 40.4 to 41.2 percent from 2019 to 2020, respectively. Of note, the number and rate of Medicaid births increased in 2020, while WIC births decreased. Further efforts are indicated to better understand the causation of maternal obesity, out-of-wedlock births, and decreasing WIC births in contrast to increasing Medicaid births and to effectively target resources and innovation in intervention and/or program development.

Program Capacity

Shifting Title V MCH and MCH Epidemiology program capacity due to the COVID-19 pandemic and related increasing staffing vacancies presented significant challenges and necessitated flexibility and agility to maintain essential MCH functions while supporting pandemic response. All MCH epidemiology and core Title V MCH team members have had additional ongoing COVID-related responsibilities. Additional information related to program capacity can be found in the MCH Workforce Development and MCH Epidemiology Workforce section narratives.

Maintaining a strong MCH system of care and ensuring seamless delivery of MCH services is vital for achieving desirable MCH outcomes. The COVID-19 pandemic presented new and exacerbated existing challenges in accessing and continuing MCH services. MCH programs remain committed to the provision of equitable, appropriate, and quality MCH services for Missouri's MCH population and continue to expand their knowledge, innovate and transition services to meet the needs of pregnant women, mothers, infants, children, youth, and CYSHCN, and their families. Additional detailed information related to the availability and access to and provision of health care services that impact the health status of the MCH population can be found in the MCH Emergency Planning Preparedness section narrative and State Action Plan narratives by domain.

Establishment of the Office of Early Childhood at the Department of Elementary and Secondary Education (DESE) in August 2021, per Executive Order of the Governor, created a consolidated location facilitating coordinated provision of early learning services for young children. (Refer to Overview of the State section for additional information.) The programs in the Bureau of Special Health Care Needs were reorganized from the Division of Community and Public Health (DCPH) to the Division of Senior and Disability Services in November 2021. Several

programs serving the MCH population, including the MCH Director and Title V MCH Program, were reorganized as part of restructuring across the DCPH. Organizational evolutionary change is ongoing, and the stress that accompanies change and reorganization cannot be prevented. However, clear communication and planning and intentional partnership and collaboration are mitigating any stress and disruption related to the reorganizations and restructuring.

Partnerships and Collaborations

To identify the priority needs of Missouri's MCH population, the Title V MCH needs assessment process sought input from community members and organizations, hospitals, non-profits, universities, LPHAs, and other state agencies. To address these priorities and implement effective strategies, the Title V Program continues to develop the relationships with these public and private entities as well as the specific organizations listed below.

The Acting DHSS Director and MCH Director attended a Maternal Mortality Roundtable hosted by Congressman Emanuel Cleaver and including state, regional and local maternal health partners. The roundtable discussion revolved around current trends, lead contributing factors to maternal mortality and severe morbidity, existing initiatives, and emerging needs related to maternal mortality in Missouri. Discussions with key partners identified the need for a Comprehensive Maternal Mortality Prevention Plan with targeted funding and initiatives to effect simultaneous transformation through five domains of action affecting maternal health:

1. Standardized, evidence-based maternal quality care protocols;
2. A Maternal Health Access Project with a single point-of-entry system for referrals to obstetrical and prenatal care providers and community agencies, resources, programs, and services and a hub and spoke model Perinatal Health Access collaborative, inclusive of perinatal mental health;
3. Multi-pronged strategies to expand, diversify and strengthen the maternal care workforce;
4. A Postpartum Plan of Care to plan for and optimize comprehensive postpartum care; and
5. Improved maternal health data collection, standardization, harmonization, transparency, and support to enhance data quality and access, identify poor outcomes during pregnancy and make improvements to support healthy pregnancy, delivery, and postpartum outcomes.

Adolescent Health Program partners include Wyman Center, Teen Pregnancy & Prevention Partnership, Society for Prevention of Teen Suicide, and Council for Adolescent and School Health. The Injury Prevention Program supports Safe Kids coalitions and participates on Missouri's Injury & Violence Prevention Advisory Committee. Partners to support CYSHCN, include Assistive Technology, University of Missouri Kansas City-Institute for Human Development, and United 4 Children. The Office of Dental Health works with the Missouri Coalition for Oral Health, Missouri Dental Association, and Missouri Primary Care Association on community outreach efforts to increase access to oral health services. Newborn Health/Early Childhood initiatives connect with child care providers, Children's Trust Fund, Home Visiting Implementation Agencies, Happy Birth Day, Inc. (Count the Kicks), and Local WIC Agencies. Statewide collaboration occurs with Missouri's Women's Health Council, Missouri's past and current Healthy Start grantees (Generate Health, Nurture KC, and Missouri Bootheel Regional Consortium), and the Missouri Hospital Association. Several Title V MCH programs work with local school districts and other state agencies, such as the Departments of Mental Health, Social Services, and Elementary and Secondary Education.

One of the largest partnerships is with the LPHAs who provide a strong local public health network of 115 city and county health departments. These agencies operate independently of each other and are independent of state and federal public health agencies. The LPHAs work directly with DHSS through contracts to deliver public health services to the communities they serve. These contracts include such programs as MCH Services, which comprises almost 30% of Title V block grant funding; CYSHCN Service Coordination; and Safe Cribs for Missouri. The LPHAs are typically the first point of contact for many Missourians seeking healthcare resources.

The #HealthierMO initiative provides a platform for transforming Missouri's public health system into a stronger, more sustainable, culturally relevant and responsive system that will allow public health experts to better meet the challenges of Missouri's diverse communities. The initiative advocates for long-term, systems-level change that will lead to healthier families, healthier communities, and a healthier Missouri. The initiative recognizes the value of interaction and input from a diverse group of public health system representatives across Missouri and covets feedback from all system stakeholders. The MCH Director is a member of the Executive Committee and has served on the Workforce Work group, Foundational Public Health Services (FPHS) Work group, and the Health Equity Design Team. The FPHS model defines a minimum set of foundational public health services and capabilities that need to be available in every community in order to have a functional public health system. The Missouri FPHS model highlights Health Equity and Social Determinants of Health as a lens through which all public health programs and services should be provided, and Child, and Family Health is one of the Foundational Areas included in the model. The Health Equity Design Team was formed in 2021 to develop a Capacity Building Program and FPHS Workbook to help equip public health professionals to operationalize Missouri's FPHS model, with health equity infused throughout all the foundational areas and capabilities.

Title V MCH Program staff facilitate internal discussions within these various units and partnerships to broaden their reach through program planning, development, and evaluation. In addition, staff participate on various external Boards, Committees, Councils, and Coalitions to make sure that initiatives meet the needs of the MCH population. Additional information regarding partnerships and collaborations is included in the Public and Private Partnerships section.

Organizational Structure and Leadership

Missouri's state government is organized into three branches: the Legislative Branch, the Judicial Branch, and the Executive Branch, which is headed by the Governor. Within the Executive Branch are 16 executive departments, including Health and Senior Services. The Department of Health and Senior Services (DHSS) is the designated state agency for the allocation and administration of the Title V MCH Services block grant funds. The Acting Department Director was appointed in March 2022. DHSS is organized into the Office of the Director, including the State Public Health Laboratory (SPHL), and four divisions: Administration, Regulation and Licensure, Senior & Disability Services, and Community and Public Health (DCPH). DCPH is the largest of the four divisions and is responsible for supporting and operating more than 100 programs and initiatives addressing public health issues.

DCPH is organized into bureaus, offices and units by types of programs and services provided and overseen by a Division Director, an operations director, two deputy directors and four assistant deputy directors. DCPH serves as the umbrella agency that facilitates access to numerous MCH-targeted programs and provides a majority of services to the MCH population. Structurally, the MCH Director and the Title V MCH Services Block Grant are now located within the Division Director's Office, and the MCH Director oversees coordination of overarching MCH initiatives and administers the Title V MCH Services Block Grant. The CYSHCN Director also serves as the Chief of the Bureau of SHCN located within the Section for Home and Community-based Services in the Division of Senior and Disability Services. Steps are being taken to create a full-time CYSHCN Director position, with the hopes of filling the position in the near future. This will increase the capacity of the Title V MCH Program to address the needs of CYSHCN beyond the population served by the programs and services in the Bureau of SHCN, strengthen statewide efforts to promote a medical home for all children with and without SHCN in Missouri, and implement family-centered, community-based, systems of coordinated care for all children with and/or at risk for special health care needs.

The functions of the Bureau of SHCN were transferred from the DHSS DCPH to the DHSS Division of Senior and Disability Services (DSDS) in November 2021. The transfer was formalized through the State FY 2023 budget

process. This was a seamless transition for participants and families served through SHCN programs. The move to DSDS will result in increased communication/coordination of Home and Community Based Programs (both Medicaid and the associated non-Medicaid services) and improved continuity of services. In addition, the move to DSDS will give SHCN programs, and the services available to families, greater attention. The work of the Bureau of SHCN aligns perfectly with the mission of DSDS, “to be the leader in advocating, partnering, protecting and supporting seniors and individuals with disabilities to be safe, healthy and independent.”

State and Federal MCH funding supports the following programs:

- Community Health Services (injury prevention, adolescent and school health)
- Environmental Health (childhood lead poisoning prevention)
- Epidemiology (vital statistics, analytics, surveillance systems)
- Healthy Children and Families (home visiting, newborn health, TEL-LINK, safe cribs, WarmLine, MCH Navigators)
- Genetics (newborn screening)
- Early Childhood (developmental monitoring, child care health consultation, inclusion specialists, parent advisory council (PAC))
- Oral Health (preventive services, community outreach)
- Special Health Care Needs (family partnership, care coordination, assistive technology)
- Women’s Health (MCH services, infant & maternal mortality, maternal substance use and mental health, health services for incarcerated women)
- Nutrition & physical activity (breastfeeding, obesity prevention)
- Crosscutting (immunizations, communicable disease prevention, health equity)

Core Title V MCH Program Staff at the DH SS

- **Martha Smith, MSN, RN, MCH Director/Public Health Nursing Manager**, has over 35 years of experience in nursing and MCH and has served in these roles since March 2019, previously serving as the Interim Director of the Center for Local Public Health Services and the MCH Services Program Manager.
- **Lisa Crandall, Bureau Chief, Bureau of Special Health Care Needs/CSHCN Director**, has worked for DHSS, Bureau of Special Health Care Needs since 2004 and has been the Bureau Chief since 2012. Lisa has served as Missouri’s Title V Children with Special Health Care Needs Director since 2016.
- **Karen Harbert, MPH, Lead MCH Epidemiologist**, has worked for the DHSS, Office of Epidemiology since 2014 and has served as the lead MCH epidemiologist since December 2020. Previously, she was a Senior Epidemiology Specialist and served as the lead for data-related issues for the MIECHV, Title V, and Children’s Trust Fund Home Visiting Programs.
- **Karyn Stewart, PHD, Senior Research/Data Analyst**, has been with DHSS in this role since August 2021. Her background includes undergraduate teaching and research in health disparities, health equity and MCH.
- **Andra Jungmeyer, MPH, State Adolescent Health Coordinator**, has over 20 years of experience in public health, with over seven years in this position.
- **Jami L Kiesling, BSN, RN, Chief, Bureau of Genetics and Healthy Childhood**, has worked in state public health over ten years, with a focus on maternal and child health. She has served in her current role since 2018, overseeing the TEL-LINK, Newborn Screening, Newborn Blood Spot Screening, Prenatal Substance Use Prevention, and Newborn Health programs.
- **Sara Gorman, MSN, RN, Maternal Child Health (MCH) Services Program Manager**, has over 11 years of state and local public health experience and served as the Central MCH District Nurse Consultant before becoming the MCH Services Program Manager in 2021.
- **Nina Nganga, MPH, Title V MCH Program Coordinator**, has been with the DHSS in this role since August

2021. Her background includes a MPH in Global Health and a certificate in Global Women's, Adolescent and Children's Health and MCH-related research in the US and Kenya.

Family Leaders

The Family Partnership provides resource information and peer support to families of CYSHCN. The Family Partnership employs four part-time professional Family Partners who are parents of individuals with special health care needs. Each serves a region of the state to assist families as well as plan, schedule, and facilitate all Family Partnership events. One Family Partner also participates on the early childhood PAC, a group of family leaders from across the state. These leaders have experience in their own communities working with agencies that provide services to at-risk families with young children and have demonstrated leadership skills. Title V provides financial support for the PAC through the contract with the DESE.

Local Public Health Agency Workforce

LPHAs protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to optimal health. LPHAs are the foundation of the local public health system, comprised of public- and private-sector health care providers, academia, business, the media, and other local and state governmental entities. In 2020, with 104 of 114 LPHAs reporting, 16 reported reducing the number of days open to the public, nine reported laying off staff, and 42 reported not replacing open staff positions, with decreased funding and the COVID-19 pandemic being cited as the primary reasons for changes in staffing, hours of operation, and provision of services.

Operationalizing Process and Findings

The Title V MCH Program used the conceptual framework provided by HRSA/MCHB as part of its needs assessment process, and followed guidance for integrating the needs of stakeholders and Missouri's diverse population through a health equity lens. The needs assessment and its activities were guided by the social ecological model (SEM). The Title V MCH Program initiated the statewide Missouri Five-Year Needs Assessment in the fall of 2018. The needs assessment timeline included capacity for the DHSS contracting process (planning), qualitative and quantitative data collection and analysis (spring 2019 – fall 2019), and stakeholder input (winter 2019 – spring 2020) before identification of the final state priorities in spring 2020.

The needs assessment was designed to enable the Title V MCH Program to assess its activities and services in relation to the state's MCH needs identified through qualitative and quantitative data sources. Selected MCH stakeholders participated in a virtual convening in April 2020, where they were briefed on the MCH block grant and an overview of findings. After reviewing additional fact sheets, stakeholders were invited to participate in an online discussion board segmented into each of the Title V domains (maternal health, infant health, child health, adolescent health, SHCN), as well as cross-cutting/SDOH. Comments were recorded from stakeholders, particularly regarding the most pressing issues affecting each population domain and the MCH system's capacity to address those issues. After two weeks of discussion, stakeholders were invited to nominally rank each potential priority option in three ways: (1) by the number of individuals impacted, (2) by the capacity of existing resources to address the issue, and (3) by political and social will to address the issue. Additionally, nearly 100 indicators were reviewed and analyzed for the needs assessment process. When numbers permitted, each indicator was broken down among multiple axes, including race, ethnicity, geography, and poverty. Trend analysis was performed on current national and state performance and outcome measures, as well as indicators of population/community health status and health system capacity.

Qualitative and quantitative data in combination with the stakeholder meeting feedback led to the identification of 8 MCH priority needs for Missouri, including 5 National Performance Measures (NPM) and 3 State Performance Measures (SPM).

Emerging Public Health Issues

Four salient topics are relatively new public health issues or public health issues of increasing severity. These topics include increased incidence of mental and behavioral health issues and suicide among adolescents, proportion of CYSHCN compared to children without a special health care need with a medical home in Missouri, ongoing impacts from the COVID-19 pandemic, and Medicaid extension for postpartum women.

Suicide among Missouri adolescents between the ages of 10-24 is the second leading cause of death for this age group (15.5 per 100,000). In 2018, 172 Missourians aged 10-24 died of suicide, making up approximately 15.2% of all suicides that year. According to Missouri's Youth Risk Behavior Survey (YRBS), the percentage of high school students who say they seriously considered attempting suicide has increased from 15.4% in 2009 to 17.4% in 2019. The percentage of high school students who say they have made a plan about how they will commit suicide has also increased from 11% in 2009 to 14% in 2019. Addressing suicide among the adolescent population is of tremendous significance. The Adolescent Health Program (AHP) addresses various health topics such as positive youth development and teen pregnancy prevention, and is instrumental in addressing suicide prevention. The AHP team provides consultation, education, training, technical assistance, and resources for health professionals, school personnel, parents, adolescents, state agencies, and community organizations. The AHP team coordinates the Council for Adolescent and School Health (CASH) to help the DHSS identify health priorities for adolescents, promote strategies to reduce health risks, and promote healthy youth development. The AHP partners to provide evidence-based suicide prevention trainings to schools and has developed a crisis toolkit for distribution to families.

Well-child visits provide important opportunities to support the whole child and address physical, behavioral, mental and emotional wellbeing, as well as conduct routine screenings, administer routine immunizations, and make early referrals to needed specialized services. The rates of well-child visits and routine childhood immunizations decreased during the COVID-19 pandemic. A patient-centered medical home facilitates patient-provider relationships to provide comprehensive primary care. In collaboration with the Missouri Chapter of the American Academy of Pediatrics, the Show-Me School-Based Health Alliance, Missouri Managed Care, and other partners, the Title V MCH team is pursuing new partnerships and strategies to ensure every child in Missouri has an identified medical home. Establishing a full-time CYSHCN Director position will play a key role in ensuring all children with and without special health care needs have a medical home. Ensuring coordinated, comprehensive and ongoing health care services for children with and without special health care needs is addressed further in the State Action Plan CSHCN Domain narrative.

The DHSS has made strides in monitoring the potential impact of COVID-19 on mothers and children. The Missouri PRAMS has collected COVID-19 data from mothers through the COVID-19 supplement since March 2021. The new Missouri PRAMS dashboard is accessible at <https://health.mo.gov/data/prams/prams-dashboard.php>. Missouri is one of 31 jurisdictions participating in the Surveillance for Emerging Threats to Mothers and Babies, which collects information on pregnant people and their children through the first 3 years of life. Related to participating in this surveillance opportunity, Missouri is linking COVID-19 case data to vital statistics files to assess the impact of COVID-19 infection on adverse pregnancy outcomes such as infant death, low birth weight and preterm births.

With the implementation of Medicaid Expansion in 2021, it is important to monitor and respond to any impacts on the MCH population. While increased access to health care may also increase the likelihood of preventive care visits among women, ensuring those eligible for care are enrolled and receive quality care are two separate issues of importance for consideration and monitoring. Medicaid Expansion also reinforces the importance of leveraging the Title V and Medicaid partnership to advance the patient-centered family medical home, ensure equitable access to

care and address the social determinants of health and health inequities. It will continue to be important for the Title V MCH Program to be proactive in engaging with partners to facilitate Expansion efforts.

Click on the links below to view the previous years' needs assessment narrative content:

[2022 Application/2020 Annual Report – Needs Assessment Update](#)

[2021 Application/2019 Annual Report – Needs Assessment Summary](#)

III.D. Financial Narrative

	2019		2020	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$12,412,817	\$11,780,449	\$13,002,609	\$12,242,452
State Funds	\$11,176,793	\$9,987,230	\$11,314,206	\$9,987,230
Local Funds	\$0	\$0	\$0	\$0
Other Funds	\$0	\$0	\$0	\$0
Program Funds	\$0	\$0	\$0	\$0
SubTotal	\$23,589,610	\$21,767,679	\$24,316,815	\$22,229,682
Other Federal Funds	\$0	\$0	\$0	\$0
Total	\$23,589,610	\$21,767,679	\$24,316,815	\$22,229,682
	2021		2022	
	Budgeted	Expended	Budgeted	Expended
Federal Allocation	\$12,971,226	\$12,299,305	\$13,088,625	
State Funds	\$9,987,230	\$9,987,230	\$9,987,230	
Local Funds	\$0	\$0	\$0	
Other Funds	\$0	\$0	\$0	
Program Funds	\$0	\$0	\$0	
SubTotal	\$22,958,456	\$22,286,535	\$23,075,855	
Other Federal Funds	\$0	\$0	\$0	
Total	\$22,958,456	\$22,286,535	\$23,075,855	

	2023	
	Budgeted	Expended
Federal Allocation	\$13,064,561	
State Funds	\$9,987,230	
Local Funds	\$0	
Other Funds	\$0	
Program Funds	\$0	
SubTotal	\$23,051,791	
Other Federal Funds	\$0	
Total	\$23,051,791	

III.D.1. Expenditures

The State of Missouri maintains the Title V Maternal and Child Health Services Block Grant (MCHBG) funding allocations and expenditures for reporting in the Statewide Accounting Management System (SAM) II. Total FFY 2021 expenditures reported for this application are from actual expenditures October 1, 2020 through June 30, 2022 and estimated expenditures July 1, 2022 through September 30, 2022. The MCHBG amount awarded to the state in fiscal year 2021 was \$12,209,355, and \$10,318,649 had been spent through June 30, 2022. Total actual expenditures from July 1, 2022 to September 30, 2022 will be included in the expenditures on the FFY 2021 Federal Financial Report.

Missouri expended \$9,987,230 of state funds, thus meeting the state match requirement set in 1989. For the majority of the match amount, Missouri utilized the core public health funds that support the screening of all infants born in Missouri for over 70 disorders within the following categories: congenital adrenal hyperplasia, cystic fibrosis, primary congenital hypothyroidism, classical galactosemia, amino acid disorders including phenylketonuria, organic acid disorders, fatty acid disorders, lysosomal storage disorders, biotinidase deficiency, hemoglobinopathies, and hearing disorders. The state also utilized the general funding expended by the Missouri Department of Corrections (DOC) for the health care costs for female offenders of childbearing age as match for the MCHBG.

The majority of the MCHBG expenditures focused on the following areas: access to care, family partnership, medical home, services for children and youth with special health care needs (CYSHCN), well women care, women's health initiatives, breastfeeding, safe sleep, home visiting, child and adolescent safety/injury prevention, oral health, nutrition and physical activity, mental health, promoting protecting factors for youth and families, ongoing MCH Needs Assessment, contracts with local public health agencies (LPHAs), and COVID-19 response.

Missouri complied with the 30%-30%-10% requirement, as specified in the guidance. The FFY 2021 annual expenditures summarized in Forms 2, 3a, and 3b by Population Health Domain and Categories as stated in the guidance are as follows:

Form 2 Expenditure Details

The detailed expenditures as listed in Form 2 are Preventive and Primary Care for Children \$3191445 (30.9%), Children with Special Health Care Needs \$3,432,474 (33.3%), and Administrative Costs \$789,473 (7.7%, which is less than the allowable 10%).

Form 3a Expenditure Details by Types of Individuals Served

The expenditures for the Types of Individual Served are as follows: Pregnant Women \$1,608,915; Infants < 1 year \$1,296,162; Children 1 through 21 years \$3,191,445; Children with Special Health Care Needs (CYSHCN) \$3,432,474; and All Others \$181.

Form 3b Expenditure Details by Types of Services

The detailed expenditures by Types of Services are as follows: Direct Services \$226,392; Enabling Services \$3,317,906; and Public Health Services and Systems \$6,774,351.

As illustrated in the table below, the MCHBG funding supported key programs within the Department of Health and Senior Services divisions of Community and Public Health (DCPH) and Senior and Disability Services (DSDS), the Office of Childhood (OoC) at the Department of Elementary and Secondary Education (DESE), and contracts with the LPHAs to improve the health and wellbeing of Missouri mothers, infants, and children, including CYSHCN.

Section	Federal Expenditures through 6/30/2022	State Match
Local Public Health Agency MCH Services Program Contracts	\$2,838,978	
Community Health Services and Initiatives (CHSI)	\$1,219,728	\$1,042,078
Environmental Public Health	\$47,283	
Epidemiology for Public Health Practice (EPHP)	\$479,908	
Section for Women's Health	\$1,146,883	
Healthy Families and Youth (HFY)	\$2,577,039	\$793,513
Dental Health	\$545,907	
Child Care Regulations	\$620,837	
Administrative	\$789,473	\$506,660
Office of Administration (ITSD)	\$52,613	
State Public Health Laboratory		\$ 6,025,887
Department of Corrections		\$1,619,092
Total	\$10,318,649	\$9,987,230

The expenditures above illustrate the breakdown of Missouri's FFY 2021 MCHBG funding to address the health and wellbeing of women of childbearing age, infants, and children, including CYSHCN. The expenditures support the MCH priorities selected by the stakeholders and partners to address the following population health domains:

Women/Maternal Health
Perinatal/Infant Health
Child Health
Adolescent Health
Children with Special Health Needs

A total of 53% (\$5,471,693) of the funding was expended for contracts with the LPHAs and other community organizations. Contract funds supported the state priorities and associated activities listed in the FFY 2021-2025 State Action Plan, along with other initiatives/activities that improve the health of the MCH population and address local MCH issues.

A total of 35% (\$3,602,163) of the funding was expended for personnel to provide program oversight and technical assistance (TA). TA was provided to contractors to assist with implementation of services and activities that impacted the MCH priorities and population. This amount also included the Section of Epidemiology for Public Health Practice staff who provide data to evaluate Missouri's priorities, and the Title V MCH Program staff, who manage the Title V MCH Services Block Grant application and budget and provide state MCH leadership and lead implementation of MCH initiatives.

A total of 8% (\$789,473) of the funding was expended for administrative costs. This was less than the maximum allowable amount of 10%.

The remaining 4% (\$455,320) of the funding was expended for DHSS program Expenses & Equipment (E&E) and

other special initiatives. E&E costs include travel expenses for meetings the MCH Director and CSHCN Director are required to attend as well as for other travel expenses, general office supplies and other costs necessary for program implementation and workforce development.

III.D.2. Budget

The Title V MCH Services Block Grant Federal Fiscal Year (FFY) 2023 application budget provides funds for maternal and infant health services, preventive and primary care for children and adolescents, and preventive and maintenance services for children with special health care needs (CSHCN). These services are managed by the programs within the Department of Health and Senior Services (DHSS) and through contracts with Local Public Health Agencies (LPHAs) and other community organizations. The DHSS and its partners meet in the spring of each year to develop funding strategies for the upcoming grant application. Programs are required to submit a budget request based on the state MCH priorities and initiatives they will be working on in the next grant cycle. After all budgets are submitted, the MCH Director, Title V MCH core team and Division of Community and Public Health (DCPH) leadership further review and approve the budget for the next fiscal year.

The FFY 2023 budget projections are based on the approved award amount for the Title V MCH Block Grant in FFY 2021. The DHSS uses the two-year prior award amount since the total current year award is not known during the budget proposal phase and/or until after the initial grant application is submitted, typically in July. With the FFY 2023 proposed use of funds, every effort will be made to maintain Title V MCH support for essential MCH programs, services, and partnerships. This year, programs requested \$13,064,561, which is \$765,256 above the amount of FFY 2021 funding received. This increase is largely due to the approved 2% increase in state employee salaries, effective January 1, 2021, an additional 5.5% increase in state employee salaries, effective March 1, 2022, and an increase in the estimated Fringe Benefit Rate from 63.61% to 68.35%. The ongoing goal is to ensure maintaining or increasing services for the MCH population in Missouri, and any additional budget needs not covered by the FFY 2023 Title V MCH Block Grant award will be funded with lapses in FFY 2022 funding. Lapses in FFY 2022 funding are primarily due to ongoing vacancies and reduced program and contractor activities resulting from the COVID-19 pandemic. If the FFY 2023 funding received and/or FFY 2022 lapsed funding is less than anticipated and/or needed, the Title V MCH Program will prioritize FFY 2023 activities and initiatives, while maintaining the core services provided for the MCH population in prior years. Similarly, any additional funding received beyond the anticipated award will be appropriately allocated to programs and initiatives serving the MCH population. Funding may also be redirected, as needed, to respond to evolving issues and assure the needs of the MCH population are addressed.

Requirements

Missouri complies with the 30%-30%-10% Title V legislative financial requirement (as indicated on Form 2) and program regulations. The budget is based upon a percentage breakdown by program, level of service, and MCH population domain(s) impacted by the services provided. The budget will meet/surpass the requirement that at least 30% of funds be used for preventive and primary care services for children and at least 30% for services for CSHCN. At 8%, the budget used to administer Title V MCH Block Grant funds is less than the 10% maximum amount allowed. The State uses its MCH Block Grant funds for the purposes outlined in Title V, Section 505 of the Social Security Act as follows:

Form 2 Annual Budget Details

The detailed budgets as listed in Form 2 are:

- Preventive and Primary Care Services for Children: \$4,060,522 (30.5%),
- Children with Special Health Care Needs: \$3,984,604 (31.08%), and
- Administrative Costs: \$1,067,496 (8.17%).

Form 3a Budget by Types of Individuals Served

The budget by the Types of Individuals Served is as follows:

- Pregnant Women: \$2,168,007

- Infants < 1 year: \$1,780,048
- Children 1 through 21 years: \$4,060,522
- CSHCN: \$3,984,604
- All Others: \$3,884

Form 3b Budget by Types of Services

The detailed budgets by Types of Services are as follows:

- Direct Services: \$294,522
- Enabling Services: \$4,294,950
- Public Health Services and Systems (includes administrative costs): \$8,475,089

Direct Services:

Direct services are preventive, primary, or specialty clinical services to pregnant women, infants and children, including children with special health care needs, where MCH Services Block Grant funds are used to reimburse or fund providers for these services through a formal process similar to paying a medical billing claim or managed care contracts. State reporting on direct services should not include the costs of clinical services which are delivered with Title V dollars but reimbursed by Medicaid, CHIP or other public or private payers. Examples in Missouri include, but are not limited to, the Kids Assistive Technology (KAT) project and Preventive Services Program (PSP). KAT projects include communication and mobility devices, hearing and visual devices, seating and mobility enhancements, and home and vehicle modifications for CSHCN. PSP is an evidence-based fluoride varnish and oral health education program that serves over 90,000 children each school year.

Enabling Services:

Enabling services are non-clinical services (i.e., not included as direct or public health services) that enable individuals to access health care and improve health outcomes where MCH Services Block Grant funds are used to finance these services. Enabling services include, but are not limited to: case management, care coordination, referrals, translation/interpretation, eligibility assistance, health education for individuals or families, environmental health risk reduction, health literacy, and outreach. Examples in Missouri include contracts for Home Visiting, CYSHCN Service Coordination, Child Care Health Consultation, services provided by the LPHAs through the MCH Services contract, and Child Care Inclusion Specialists.

Public Health Services and Systems:

Public health services and systems are activities and infrastructure to carry out the core public health functions of assessment, assurance, and policy development, and the 10 essential public health services. Examples include the development of standards and guidelines, needs assessment, program planning, implementation, and evaluation, policy development, quality assurance and improvement, workforce development, and population-based disease prevention and health promotion campaigns for services. Examples in Missouri include the injury prevention program, adolescent health program, comprehensive school health program, safe sleep program, obesity prevention program, breastfeeding program, and prenatal substance use prevention. Also included are MCH Epidemiological Services and program evaluation, MCH workforce capacity and technical assistance for program coordination and systems development, and LPHA community-based system building through the MCH Services contract.

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT FFY 2023 PROPOSED USE OF FUNDS		
FUNDING	PROPOSED FFY 2023	
TOTAL FUNDS APPLIED FOR	\$ 13,064,561	
FUNDING BY SERVICE LEVELS	PROPOSED FFY 23	SUBTOTAL
<i>Direct Care Services</i>		
Assistive Technology	\$ 100,000	
Oral Health Services	\$ 193,356	
Childhood Lead Poisoning Prevention	\$ 5,084	
Total Direct Care Service		\$ 298,440
<i>Enabling Services</i>		
DESE office of Childhood	\$ 1,793,439	
LPHA MCH Services Contracts	\$ 878,518	
CSHCN Service Coordination	\$ 1,268,614	
Family Partnership	\$ 67,892	
Lead Hazard Reduction/Abatement	\$ 78,982	
Oral Health Services	\$ 157,505	
Total Enabling Services		\$ 4,244,950
<i>Public Health Service and Systems</i>		
Adolescent Health	\$ 89,000	
DESE Office of Childhood	\$ 679,598	
Coordination and Systems Development	\$ 2,798,088	
Epidemiological Services	\$ 712,446	
Genetic Services	\$ 23,120	
Healthy Families	\$ 130,873	
Injury Prevention	\$ 100,000	
LPHA MCH Services Contracts	\$ 2,635,553	
Nutrition Projects	\$ 18,311	
Obesity Prevention	\$ 19,000	
Oral Health Services	\$ 47,000	
Outreach and Education (TEL-LINK)	\$ 36,419	
School Health	\$ 20,000	
Women's Health Initiatives	\$ 144,266	
Total Public Health Service and Systems		\$ 7,453,674
Administration	\$ 1,067,496	
		\$ 1,067,496
Grand Total		\$ 13,064,561

Maintenance of Effort/Match

The state's maintenance of effort level from 1989 is \$9,987,230, and the state's calculated match requirement for fiscal year 2023 based on the planned budget total is \$9,987,230. The total Federal and State Funds budget includes projected expenditures identified as benefitting the health of the Title V populations in Missouri. These funds come from the Title V MCH Services Block Grant and state general revenue. The Federal expenditures are within the DHSS, where the Title V MCH Program resides, though not specifically under the organizational authority of the MCH Director. The majority of State Funds are for newborn screening through the DHSS State Public Health Laboratory, direct care for CSHCN, and services provided to women of childbearing age (excluding those who are HIV positive) through the Missouri Department of Corrections. This program provides a critical public health service to the MCH population and is aligned with the National Performance Measures.

As illustrated in the table below, the MCH Block Grant and State funding supports key programs within the DHSS Division of Community and Public Health (DCPH) and the DESE Office of Childhood. Funding also supports maintenance for specific MCH data systems and providing health services to incarcerated women.

DHSS	Federal Funds (Title V)	State Funds
Special Health Care Needs	\$1,437,506	
Community Health Services and initiatives	\$4,758,506	\$1,022,970
Environmental Public Health	\$90,422	
Epidemiology for Public Health Practice	\$712,446	
Healthy Families and Youth	\$1,026,161	\$12,622
Office for Women's Health	\$224,675	
Office of Dental Health	\$676,972	
State Public Health Laboratory		\$6,358,629
DCPH Director's Office	\$511,623	
Administrative	\$1,067,496	\$506,660
DESE Office of Childhood		
Home Visiting	\$1,578,546	
ECCS & PAC	\$56,317	
Safe Cribs	\$48,563	
Child Care Health Consultation	\$247,866	
Child Care Inclusion Services	\$455,997	
Contract Indirect	\$85,749	
Office of Administration		
Information Technology Services Department	\$85,716	
Department of Corrections		
Services for Incarcerated Women		\$1,286,349
TOTAL	\$13,064,561	\$9,987,230

*Information about the structure and programming of DHSS can be found in the Title V Program Capacity section of the application.

The budget supports the state's priorities to address all five population health domains:

Women/Maternal Health
Perinatal/Infant Health

Child Health
Adolescent Health
Children with Special Health Needs

A total of 52% (\$6,737,839) of the funding is for contracts with the LPHAs and other community organizations. Contract funds support the state priorities and associated activities listed in the FFY 2021-2025 State Action Plan.

A total of 35% (\$4,640,574) of the funding is for personnel to provide program oversight and technical assistance (TA). TA is provided to contractors to assist with implementation of services and activities that impact the MCH priorities and population. This amount also includes the Section of Epidemiology for Public Health Practice staff who provide data to evaluate Missouri's priorities, and the Title V Program staff, who manage the Title V MCH Services Block Grant application and budget.

A total of 8% (\$1,067,496) of the funding is for administrative costs.

The remaining 5% (\$618,652) of the funding is for DHSS program Expenses & Equipment (E&E). E&E costs include travel expenses, general office supplies and other costs necessary for program implementation and workforce development.

III.E. Five-Year State Action Plan

III.E.1. Five-Year State Action Plan Table

State: Missouri

Please click the links below to download a PDF of the Entry View or Legal Size Paper View of the State Action Plan Table.

[State Action Plan Table - Entry View](#)

[State Action Plan Table - Legal Size Paper View](#)

III.E.2. State Action Plan Narrative Overview

III.E.2.a. State Title V Program Purpose and Design

Partnership and Leadership Roles

Missouri has a rich history of providing support for and creating state partnerships that support the promotion and improvement of the health and well-being of the state's mothers, infants, and children, including children and youth with special health care needs (CYSHCN). The maternal child population is one of our most vulnerable populations, and Title V is the umbrella program that supports multiple programs targeting this population to coordinate activities and pool resources. A host of qualified health professionals oversee/implement the programmatic aspects of the Title V MCH Block Grant throughout the state. This includes a Core Team to provide Title V Program direction and carry out the daily and ongoing processes of the block grant with a focus on all five population health domains.

Missouri convened a new DHSS MCH Steering Committee comprised of Title V Core Team members (listed in the Workforce Capacity section of the application), the Title V Family Delegate, and other DHSS staff who implement programs that impact the MCH population. This group provides leadership, accountability, and oversight to the state's MCH efforts; set a strategic direction for the Title V Program; serve as the key decision-making body for program-wide activities; and identify and provide support to state and local level efforts. The Steering Committee ensures Title V MCH Program efforts address the purpose of the MCH Block Grant and its Vision and Mission statements.

The Steering Committee is working with the Title V MCH core team to form an Advisory Committee, comprised of external partners such as local public health agency (LPHA) representatives, family/parent advocates, adolescents, and other state agency associates, and representative of the urban/rural and demographic composition of the state. The goal is for the Advisory Committee membership to include professionals with expertise in MCH services, consumers with an interest in the health of mothers and children, and individuals who can speak to the specific needs of the MCH population in Missouri. Members will advise the Steering Committee on statewide priorities by providing ongoing guidance and support to Title V and MCH initiatives, informing strategies and measures for the Title V State Action Plan, identifying and responding to emerging MCH issues, and supporting ongoing needs assessment efforts and public input.

Missouri's Title V Program maintains active partnerships with local and state agencies including, but not limited to 115 LPHAs, Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), Department of Mental Health (DMH), Missouri Hospital Association (MHA), Missouri Foundation for Health, HealthierMO, Missouri Chapter of the American Academy of Pediatrics (AAP), American College of Obstetricians and Gynecologists (ACOG), Show-Me School-Based Health Alliance, Community Health Workers Association of Missouri, Children's Trust Fund, ParentLink, University of Kansas City- Institute for Human Development, and schools of nursing and public health. Title V MCH team members participate on and lead various state committees and initiatives, such as the Healthy Start Collaborative, Early Childhood Coordinated Systems Steering Committee, Missouri Injury and Violence Prevention Advisory Council, and the Coalition for Adolescent and School Health, to collaborate with stakeholders and strategically align goals and activities. Through partnerships with federal agencies, the Title V Program receives technical assistance, evidence-based resources, opportunity for creative thinking and constructive critique, and training to enhance Missouri's capacity to promote the health and safety of the MCH population.

Serving as a Convener, Collaborator, and Partner to Address MCH Issues

The unique needs of the MCH population are even more important in the midst of the chaos and uncertainty of an emergency, and the COVID-19 pandemic has highlighted the special considerations for the MCH population that

must be addressed to ensure the delivery of quality health care services to assure the health and safety of Missouri's mothers, infants and children, including CYSHCN. During the COVID-19 pandemic, the Title V Program has advocated with internal and external partners and supported partner efforts to promote telemedicine and teledentistry for the MCH population as appropriate; adequate prenatal care; well-child visits; routine childhood immunizations; health and safety of children and adults in the school setting; COVID vaccination for women of childbearing age, pregnant women, fathers, and adolescents; equitable testing, treatment, and vaccine availability and delivery; and strengthening social supports, assuring social services equity, and removing barriers to social justice. The Title V Program shares updated federal and state guidance with internal and external partners and encourages partners to share with additional partners and the individuals and families they serve. The Early Childhood Comprehensive Systems (ECCS) works with communities to improve early childhood outcomes by providing opportunities for implementation of the Missouri Early Childhood Strategic Plan for Missouri's children and their families. The strategic plan was revised as part of the Preschool Development Grant: Birth to Five (PDG). The PDG is a federal grant awarded to the DESE. The strategic plan focuses on three main goals of Building Strong Systems, Bridging Access and Quality, and Boosting Supports. The PDG Activity Team is a key partner in the coordinated enrollment plan for the early care and education systems and involves representatives from Title V funded programs such as home visiting, Child Care Health Consultation (CCHC), ECCS, and MCH Services. Numerous organizations and services for young children and their families have existed for many years in the State of Missouri. Nonprofit organizations, government agencies, corporations, individual businesses, and informal groups have provided a wide range of supports to help young children thrive. Many of these supports, however, have been fragmented and disconnected. Families have not always known about the resources available to them. ECCS has attempted to examine these services more comprehensively and link them into a more effective, unified system that aims to support families and communities in promoting optimal development of all young children in Missouri.

As a key stakeholder in Missouri's early childhood system and a funder of programs serving young children and families, including the programs that moved from the DHSS to the Office of Childhood at DESE, the Title V Program is centrally involved in the coordination of efforts to integrate early childhood programming, maximize the effectiveness of the early childhood services, and enhance family access to early childhood resources and services. The formal relationship between the Title V MCH Program and the Office of Childhood is established through an interdepartmental contract with a detailed Scope of Work.

Title V Framework

Like many Title V programs, the Life Course Perspective is a conceptual framework for understanding and addressing disparities in maternal and child health. The MCH Director facilitates An Interactive Simulation, Application and Discussion of the Life Course Framework for internal and external MCH programs and partners, including LPHAs, undergraduate and graduate students, and community organizations. To address the eight MCH priorities, apply the two overarching principles, eliminate health disparities, and create safe, stable, and nurturing relationships and environments for children and families in Missouri, the Missouri Title V MCH FFY 2021-2025 State Action Plan strives to integrate the Life Course Perspective throughout initiatives, strategies and activities and implement the following Association of State and Territorial Health Officials (ASTHO) recommendations to address and prevent adverse childhood experiences (ACEs) across the lifespan:

- utilize a population health approach that engages cross-sector partners, uses data to drive efforts and monitor progress, fosters resilience, and cultivates a trauma-informed workforce;
- support policy and environmental changes across sectors to strengthen household financial security and economic self-sufficiency and develop a trauma-informed state government, where all employees are trained in trauma informed concepts and all agencies have a stake in addressing ACEs as a cross-cutting issue;
- cultivate a competent and trauma-informed MCH workforce that understands the underlying causes of health disparities;

- use data to inform prevention programs and policy and to identify at risk populations or geographic areas to implement context-specific prevention initiatives;
- engage cross-sector partners to support the social and emotional well-being of children and their families;
- work collaboratively with trusted family venues (e.g. faith based, barber shops, and other community centers) to influence family services that fall outside the realm of clinical practice;
- support centralized access points, care coordination efforts, and community leadership and infrastructure to link children and families to universal and targeted services;
- implement prevention approaches that promote prosocial and healthy behaviors at the individual and familial levels, such as evidence-based programs that support positive parenting skills, and foster resilience by enhancing social-emotional protective factors;
- support rigorous program evaluation to demonstrate effectiveness of programs, especially those designed to address and prevent ACEs;
- protect and increase investments in early childhood development, home visiting, and trauma-informed services for low-income children and families; and
- support and fund evidence-based home visiting programs to assess and address family needs and connect families to appropriate services.

Utilizing the Strengthening Families Protective Factors Framework from the Center for the Study of Social Policy, Missouri's Title V MCH Services Block Grant Program works to engage families, programs, and communities in building key protective factors to mitigate risks, promote positive well-being and healthy development, and help families successfully navigate difficult situations and improve outcomes. The Title V MCH Block Grant in Missouri will continue to fund contracts with LPHAs to support a leadership role for LPHAs at the local level to: build community-based systems and expand the resources those systems can use to respond to priority MCH issues; provide and assure mothers and children (in particular those with low income or with limited availability of health services) access to quality MCH services; reduce health disparities for women, infants, and children, including those with special health care needs; promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and promote the health of children by providing preventive and primary care services for low income children. Local, regional and statewide initiatives and programs funded by the Title V MCH Block Grant will provide leadership for and enhance community capacity to address and prevent ACEs across the lifespan and build key protective factors that enable mothers, infants, children, and families to thrive.

Successes/Challenges/Emerging Issues

Missouri's Title V Program continues to anticipate and adjust to the impact of the COVID-19 pandemic on the communities we serve. Efforts to respond to the pandemic have been supported within the guidelines allowed by the Maternal Child Health Bureau (MCHB) of the Health Resources and Services Administration (HRSA). The Bureau of Special Health Care Needs (SHCN) collaborated extensively with MO HealthNet to coordinate services for Healthy Children and Youth (HCY) and Medically Fragile Adult Waiver (MFAW), including substantial work on the 1135 and Appendix K, which allows states some flexibility for implementation due to the public health emergency. As LPHAs continued to shift their work to respond to the pandemic, some FFY 2021 MCH Services contract requirements were waived to allow the use of contract funding to implement science-based approaches to combat the disease and address related MCH population needs. Response efforts also included Title V MCH staff time to work in the Missouri Novel Coronavirus Information Hotline call center as well as assist with data entry, data processing, and contact tracing. The MCH Director participated in daily COVID Emergency Response Center Activation calls for pandemic information sharing and situational awareness and served as a panelist in weekly virtual meetings of the MO Advisory Committee on Equitable COVID-19 Vaccine Distribution. In August 2021, the Governor terminated Executive Order 20-02, ending the State of Emergency that had been in effect since March 13, 2020, and issued Executive Order 21-09, a more targeted State of Emergency declaration that acknowledged the continued needs of

Missouri's health care system and activated the Missouri National Guard for continued mission support in recovery operations, if needed. Executive Order 21-09 also maintained provisions related to remote notary services and telehealth and allowed state agencies to request waiver of certain statutory and regulatory requirements that would hinder response to ongoing COVID-19 challenges. Executive Order 21-09 terminated on December 31, 2021.

Foundation for Family and Community Health/Access to Care

Supporting Coordinated, Comprehensive, Family-Centered Systems of Care

The Title V MCH Program supports service coordination through the Children and Youth with Special Health Care Needs and HCY programs to help families develop and obtain high quality supports and services to meet their needs. Early childhood home visiting programs are offered to ensure children have the opportunity to grow up healthy, safe, and ready to learn and be able to become productive members of society. Title V MCH Program team members also work to develop meaningful partnerships with schools, child care providers, state departments/associations, local organizations, and community groups to promote systems of care that benefit the MCH population and overcome issues preventing access to care.

Innovative Approaches to Address Crosscutting Issues

Missouri's Title V Program works with partners to engage community stakeholders who work closely with the MCH population. Suicide remains the tenth leading cause of death for all ages among Missouri residents and the second leading cause of death among adolescents 10-19 years old. Youth suicide rates in rural counties are higher than more urban areas, Missouri is under-resourced with mental health professionals, and there is a gap in mental health resources, which is especially prominent in rural areas. The Title V, Injury Prevention and Adolescent Health programs partnered to participate in the Children's Safety Network (CSN) Child Safety Learning Collaborative (CSLC) Suicide & Self-Harm Prevention Cohort 2. The CSLC team vision aimed to:

- decrease suicide-related fatalities, self-harm-related hospitalizations, and emergency department visits through the implementation and spread of evidence-based suicide and self-harm prevention strategies and programs;
- Strengthen collaboration across agencies, develop new tools and capacity, and implement evidence-based change in Suicide and Self-Harm prevention strategies; and
- renew focus on Suicide and Self-Harm prevention as a high priority issue for adolescent injury prevention in Missouri.

A workgroup was formed with partners including DMH, DESE, the Association of Secondary School Principals, public school teachers and staff, Wyman, Inc., the DHSS Coordinated School Health Program, LPHAs, parents, and adolescents. Led by the Injury Prevention Program, the workgroup developed a Mental Health Crisis Toolkit, based on the Society for the Prevention of Teen Suicide (SPTS) toolkit for use in emergency room settings with families of youth experiencing a mental health crisis. The Mental Health Toolkit is a resource for schools to give parents who have a child experiencing a mental health crisis. The toolkit provides families with comprehensive resources and guidance, promotes reduction of shame and prejudice around mental illness, normalizes seeking mental health services, recognizes the different experiences and unique needs of socially disadvantaged populations, and provides equitable system wide opportunities to help all students thrive. The DHSS partnered with stakeholders such as LPHAs, Missouri School Board Association (MSBA), and school nurses working to address mental health to distribute the adapted toolkit to local school districts.

Implementing Core Public Health Functions

Assessment

The Title V Program is supported by a robust data infrastructure, which includes the MCH epidemiology team that primarily supports the Title V block grant application, needs assessment, and provides crucial data and analytical

support. Title V staff also provide technical assistance to both internal and external partners with respect to MCH data analysis and interpretation. Functions include: monitoring MCH indicators; presenting MCH-related data to internal and external stakeholders; leading the Five-Year Needs Assessment and ongoing needs assessment processes; updating and maintaining datasets; program planning, reporting, improvement, and evaluation; data dissemination; data analysis; and ensuring data quality, integrity, and processing. Data is gathered from the Pregnancy Risk Assessment Monitoring System (PRAMS), Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Survey (YRBS), Fetal and Infant Mortality Review, teen birth and pregnancy rates, Missouri Child Health Assessment Program Survey (MoCHAPS), Home Visiting programs, State Systems Development Initiative (SSDI), and Birth Defect Surveillance, among other relevant sources. The Title V core team sought technical assistance from the MCH Workforce Development Center and is in the process of revising the national and state performance measure objectives with the goal of making them specific, measurable, attainable, relevant, and time-based (SMART). Additionally, the Evidence-based or –Informed Strategy Measures (ESMs) will be revised to progress from process measurement to impact/outcome measurement. This will allow the Title V MCH Program to evaluate whether Title V funded program activities are meeting the targeted goals.

Policy Development

Missouri communities perform the policy development and planning function when they use assessment information to set priorities. They work in collaboration with their governing bodies, or other local policy makers, to develop policy, allocate resources, and implement strategies to improve the health of their communities. Almost 30% of funds from the Title V block grant are distributed to the MCH Services Program, which contracts with 111 LPHAs to address the needs of their local MCH population. Each LPHA submitted a five-year work plan with annual contract renewal. The MCH Services Contract priority health issues (PHI) are set to align with the Title V MCH Block Grant national and state priorities in order to focus on a more comprehensive statewide impact. Using local data and input from community members and partners, the LPHAs conducted focused local assessments of the priority MCH issues in their community and used the Title V MCH Block Grant priorities as a guide to identify their FFY2022-2026 MCH Services contract PHIs. Each work plan identifies: targeted national, state, and/or local outcome measure(s); a statistically descriptive statement of the problem; goals for addressing the stated problem; and evidence-based strategies that will be used to address the problem. Also identified are system outcome(s) and multifaceted, progressive activities at each of the six levels of the Spectrum of Prevention, which includes influencing policy and legislation and changing organizational practices.

Assurance

Missouri's Title V programming: assures communities have the information, resources, and strategies they need to maximize the health of their residents; assures the public has access to culturally appropriate, accurate, and current information that they need to make decisions about their health care options; provides health promotion, education, and disease prevention programs in the community; educates health providers about public health issues; helps assure access to care; and implements quality improvement processes to achieve measureable improvements in outcomes and other indicators of quality in services or processes, which contribute to increased equity and improved community health. LPHAs must establish a process for tracking and monitoring progress and analyzing performance trends to measure work plan effectiveness in achieving the targeted changes in the local community systems and revise work plan activities as necessary to improve effectiveness. The FFY 2021-2025 Title V State Action Plan was intentionally reimagined from the FFY 2016-2020 State Action Plan to identify general strategies to achieve the identified objectives and overall vision. FFY 2021 was intended to be a continued planning year with further identification and planning of shorter-term priorities, performance initiatives and specific action steps, detailing the "who, what, and when" related to the resources to be leveraged, and the establishing the "how" of achieving the objectives. The ongoing diverse, cross-sectional impacts of the COVID-19 pandemic necessitated continuing these processes into FFY 2022, while also maintaining work in progress. Internal MCH programs and external contractors will continue to be challenged to identify evidence-based performance initiatives and action steps that align with the

general strategies and will contribute to achieving the objectives and performance targets established in the ESMs (Evidence-based or –Informed Strategy Measures).

III.E.2.b. State MCH Capacity to Advance Effective Public Health Systems

III.E.2.b.i. MCH Workforce Development

Recruitment and Retention

Like most employers, the state of Missouri and the Department of Health and Senior Services (DHSS) have been affected by “The Great Resignation”. The public health sector has been especially affected by people leaving the field due to the increased work-related stress created by the pandemic. The DHSS Office of Human Resources recently developed a retention strategies plan, which was shared with all supervisors and managers. Strategies recommended included reviewing recruiting/hiring practices, understanding team effectiveness, exploring flexible scheduling, and utilizing stay interviews. The state Office of Administration launched the [MO Appreciation](#) website to show appreciation to colleagues and strengthen the culture of recognition. The website was designed by state team members, for state team members, as a one-stop shop to provide team members access to resources, ideas, and recognition opportunities.

Although the Title V MCH supported programs have experienced numerous departures over the past two years, there has been a rebound in recent months. Many vacant positions have been filled, and the new team members have been trained and are actively contributing to MCH efforts. The Title V MCH Program works closely with multiple units throughout the DHSS. Many DHSS staff have worked for the Department for many years, strengthening the knowledge base, needs assessment, and expertise both in public health and MCH. Unit managers and supervisors are responsible for ensuring that staff are qualified, properly trained, and informed on current public health issues.

MOCareers is the state hiring platform for finding a career in Missouri government, browsing state job listings, exploring job openings for individual state agencies, applying for posted positions, viewing state benefits, and more. Ongoing expansion to MOCareers (HireTrue) has continued to evolve and change how state agencies hire and onboard new team members. Expansion of MOCareers (HireTrue) requires less staff time to move positions and applicants through the hiring process and has increased consistency and efficiency in overall hiring processes. Weekly “Did you know...” emails highlight specific platform functionalities and useful nuggets of information.

For additional information regarding Missouri’s Title V MCH Workforce, please see the Missouri Title V Workforce Information Sheet on the next page.

Missouri Title V MCH Workforce Information Sheet

Title V MCH Program Workforce FTEs	
1.	Title V MCH Funded Positions: 119 positions/FTEs (not including ITSD) are funded in part or whole with Title V funding Total Number of FTEs: 52.47 Total FTEs
2.	New Title V MCH Funded Team Members Onboarded in Past Year Total Number of New FTEs: 31 Positions representing 13.435 FTEs____ Types of Positions: <ol style="list-style-type: none"> 1) MCH/Title V Coordinator 2) MCH Research/Data Analysts 3) Program Managers 4) MCH Registered Nurses 5) Public Health Program Specialists 6) Administrative Support Staff
3.	Title V MCH Funded Positions Currently Vacant Total Number of Vacant FTEs: 14 Positions representing 5.834 FTEs Types of Positions Vacant: <ol style="list-style-type: none"> 1. CYSHCN Director 2. Program Managers 3. MCH Epidemiology team members 4. CYSHCN team members 5. MCH Registered Nurses 6. Project & Program Specialists 7. Program & Administrative Support Staff 8. DHSS Medical Director
Training Needs and Resources	
1.	Current or Anticipated Title V MCH Professional Development and Training Needs <ol style="list-style-type: none"> 1. Core MCH and Title V MCH Block Grant training for new Title V Funded Team Members 2) Leadership Development 3) Ongoing training, technical assistance, and education related to Core MCH and Title V MCH Block Grant concepts, new resources, new guidelines, emerging needs, innovative strategies, etc._____ 4) Health equity training _____ 5) MCH Epidemiology training _____ 6) Building program and policy evaluation capacity
2.	Key Resources/Partners Needed to Meet Title V MCH Professional Development and Training Needs <ol style="list-style-type: none"> 1. State of Missouri and DHSS Leadership Support 2. HRSA/MCHB 3. AMCHP: Leadership Lab, Annual Conference, Learning Collaboratives, Webinars, MCH Essentials Series, Resource Library, TA, etc. 4. MCH Navigator 5. National MCH Workforce Development Center 6. MCH Evidence Center 7. CityMatCH Conference, Life Course Toolbox, Epidemiology Training, Webinars, Resources, etc.

Training and Growth Opportunities

The Missouri Way training series incorporates approaches proven successful in other high performing organizations in both the public and private sectors and was established to equip state team members with tools and techniques to become the best public servants possible and to drive change for the citizens of Missouri. The training was originally designed as an intensive 3-day training program to introduce senior leaders, managers, supervisors, and other emerging leaders to tools and approaches to solve basic management challenges and improve their team's performance. The training series has now been transitioned to a new e-learning format available to all state employees. The new e-learning series is an essential part of the State of Missouri's plan to improve its performance and develop a culture of continuous improvement.

The Missouri Way objectives are to:

- Accelerate participants professional growth through individual leadership development, building new skills to lead others and lead change
- Provide department leaders the skills and shared understanding needed to improve team performance and cultivate a strong, positive work environment
- Develop needed skills amongst team members across the State of Missouri to improve government performance for our citizens

The curriculum includes sessions on change management, continuous improvement, project management, customer experience, communications, performance measures and dashboards, and building and leading and provides common approaches, tools, and vocabulary in the following learning paths:

- Advanced Teams/Lead others
- Initiative Team Boot Camp
- Facilitation for Change Agents
- Lead Change
- Lead Self
- Performance Measures and Dashboards and
- Show Me Excellence

All state employees now have access to online professional development content through MO Learning, a world-class online training platform powered by LinkedIn Learning. State employees have access to an online library of over 16,000 high-quality courses that can be accessed through office computers or on a mobile device. A wide range of course topics pertinent to professional development is available, and a list of initial course recommendations is available for team members, supervisors, and managers.

The FFY 2021-2025 Title V MCH State Action Plan includes the development and implementation of a Title V Core MCH, health equity, and racial justice training plan. The goal is to build core competencies of internal program staff and external contractors to increase knowledge and awareness of the basic principles of MCH, health equity, and racial justice. The trainings will impart practical skills to apply this understanding across all programs, practices, and interventions. The MCH Director serves on the DHSS Foundational Public Health Services Workgroup, Division of Community and Public Health Strategic Planning group, and Preventive Health and Health Services (PHHS) Block Grant Advisory Council. The MCH Director also serves as the state Public Health Nursing (PHN) Manager and facilitates public health nursing workforce development and other public health nursing initiatives. This includes providing PHN consultation and presentations and managing the PHN Discussion Listserv, which allows public health nurses to share messages, announcements, events, etc. and/or pose questions pertinent to public health nursing.

For many years, the Missouri Council for Public Health Nursing was organized within the DHSS and provided leadership, expertise, and advocacy related to public health nursing practice, standards, and issues. In 2022, the Section for Public Health Nursing (SPHN) was established within the Missouri Public Health Association (MPHA) to address issues that impact public health nursing within the public health system. Through a letter of agreement between the DHSS and MPHA, the Missouri Council for Public Health Nursing membership was transitioned to the MPHA SPHN. The SPHN includes representation from the DHSS, local public health agencies (LPHAs), nursing academia, and other public health related organizations. The SPHN will continue the provision of leadership, expertise, and advocacy related to public health nursing practice, standards, and issues. The MCH Director, MCH Program Manager and MCH district nurse consultants are active members of the Missouri Public Health Association (MPHA) and the Section for Public Health Nursing (SPHN). The MCH Director serves as a member of the SPHN Executive Committee. The MPHA and the DHSS, along with other public health organizations, sponsor an annual public health conference, allowing program staff to network with LPHA and other public health partners and grow their expertise to serve as a resource in regards to issues that impact the MCH population. Two PHN awards are given annually during the conference to celebrate and acknowledge the great work of Missouri's Public Health Nurses and recognize a public health nurse and public health nursing leader.

The Family Partnership Parent & Caregiver Retreat provides an opportunity for families to network with one another, discover resources to assist their family, enrich their leadership and partnering skills, and plan a vision for their family's future. The Retreat is a free event designed for Missouri parents, legal guardians, and caregivers of children, youth, and young adults with special health care needs. The Bureau of Special Health Care Needs plans to host a Retreat in FY 2023. More information on the trainings can be found in the Children with Special Health Care Needs Annual Report under NPM #11 Medical Home. The Missouri Parent Advisory Council (PAC) is intended to provide in-person trainings for specific projects that members may become involved with at the state level. Training may also include attending out-of-state conferences that would benefit both the individual member and the PAC as a whole. More information on current PAC efforts can be found in the Family Partnership Section.

To improve capacity, Title V MCH Program partners attend national trainings such as the AMCHP conference, CityMatCH Leadership and MCH Epidemiology conference, MCH Partnership Technical Assistance meetings, and other MCH conferences, summits, symposiums, etc. Participation in Collaborative Improvement & Innovation Networks (CoIIN) and National MCH Workforce Development Center Cohorts are encouraged, when applicable. Regional and statewide trainings, such as biannual regional public health meetings and the annual Missouri Public Health Conference, are available to program staff, LPHAs, and other community stakeholders to provide an opportunity to network and learn new information relevant to the MCH population. Program staff also attend trainings specific to their program areas. Although the merit of in-person convenings cannot be underestimated, the increase in virtual and hybrid conference and training opportunities allows a greater number and diversity of team members to participate and benefit.

Missouri was invited to participate in the 2022 MCH Roundtable hosted by the National Governors Association (NGA) Center for Best Practices. The roundtable consisted of state leaders, MCH organizations and federal partners. The MCH Director joined the roundtable to share strategies and lessons learned from impacts of the COVID-19 pandemic on Missouri's MCH programs, discuss MCH policy issues including workforce, community supports, mental health, child care, etc., and offer important insights for the development of a NGA publication with policy considerations for state leaders.

Innovations in Staffing Structures and Workforce Financing

As discussed in the Health Care Delivery Systems section, the State Dental Director position is funded through an income-sharing agreement between the DHSS and DSS. This allows for coordinated statewide efforts with Medicaid dental services and Oral Health Program initiatives. Inter- and intradepartmental communication and

collaboration ensures oral health is considered in a variety of programs and settings.

The SHCN Family Partnership is funded primarily through the Title V MCH Block Grant and secondarily through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant. Title V MCH funds four Family Partners, and the HRSA grant provides funding to employ two additional Family Partners who are parents of children who are deaf or hard-of-hearing (FP-DHH) to support Missouri families involved in the early hearing detection and intervention (EHDI) process. More information on this can be found in the Children with Special Health Care Needs NPM #11 Medical Home Annual Report.

Title V MCH Program team members serve as preceptors for undergraduate and graduate nursing and public health student intern experiences, with the students completing a capstone project in MCH and/or epidemiology. In addition to presenting to public health graduate students on Missouri's Title V MCH Services Block Grant Program and the Life Course Perspective, the MCH Director serves on the Advisory Council for the Saint Louis University Center of Excellence in Maternal and Child Health Education Science and Practice to provide maternal and child health scholars with exceptional academic, research, leadership and practical training. The MCH Director is collaborating with an assistant professor of nursing at Missouri State University and a doctorally-prepared local public health nurse leader and Community Outreach Specialist to query community/public health nurses about their experiences utilizing the Council of Public Health Nursing Organizations Community/Public Health Nursing Competencies during the Covid-19 pandemic. Study design and findings will be presented at the 2022 Public Health Conference and submitted for publication in a peer-reviewed journal.

To conduct a comprehensive review of FTE linkages to grant requirements and assess staffing needs, available resources, and Personnel Services appropriations, DCPH leadership engaged managers across the Division to detail FTE linkages across a number of categories. Using a Linkage Tool, FTEs were categorically assigned to categories based on statutory and regulatory mandates, grant requirements, grant deliverables, grant objectives and strategies/activities, and requirements of subcontractors. The completed Linkage Tools were then used to prioritize FTEs to reflect grant needs and public health transformation efforts. Managers were also asked to forecast what each FTE may look like in 2023 and 2025 and to present ideas for how to decrease the number of FTE needed through implementing contracts for services, new technology, and other operational innovations for human resource efficiency. Title V MCH suggestions for ways to decrease the number of FTEs needed and increase human resource efficiency included:

1. Organization of all programs primarily/solely serving the MCH population in the same Section to improve communication and collaboration and promote alignment of effort, maximizing collective impact and minimizing duplication of effort and inefficiencies; for example, sharing of human resources such as clerical and program support staff and sharing of physical resources such as IT equipment and office supplies would result in cost savings, allowing maximization of grant funding; and
2. Development of an online Title V MCH Data & Reporting Management System to:
 - facilitate the process of data collection and analysis;
 - promote more seamless integration with HRSA's Electronic Handbooks and grants management system (i.e. TVIS);
 - electronically capture financial, program and performance data, incorporating data from multiple programs and contractors and pre-populating Title V MCH report forms;
 - electronically link state priority needs, National Outcome Measures, National Performance Measures, and Evidence-Based or Informed Strategy Measures to programmatic and contractor efforts, including contract work plans, reporting and outcomes data collection for MCH contracts;
 - provide Title V MCH with the tools and capacity to more fully and efficiently demonstrate the effectiveness and impact of the Title V MCH Program; and

- reduce burden, increase efficiency and improve accountability overall.

The FFY 2021-2025 Title V MCH State Action Plan priorities and national and state performance measures are forecasted to remain essentially unchanged through September 30, 2025, requiring adequate Title V MCH leadership and support FTEs and MCH program FTEs to accomplish the strategies and meet the objectives and evidence-based strategy measures included in the State Action Plan and to meet HRSA/MCHB Title V MCH deliverables. Many of the programs and FTEs supported by Title V MCH funding are also supported by other short-term grants, and, in many instances, those programs and FTEs are integral to the Title V MCH State Action Plan and will rely on Title V MCH funding for ongoing support.

Local Public Health Agency (LPHA) Workforce

In 2020, 16 LPHAs reported reducing the number of days they are open to the public, nine reported laying off staff, and 42 reported not replacing open staff positions, with decreased funding and the COVID-19 pandemic being cited as the primary reasons for changes in staffing, hours of operation, and provision of services. From March 1, 2020 to August 20, 2021, 33 LPHA Administrators vacated their positions, representing 29% of the 115 LPHA administrator positions across the state, with additional LPHA administrator retirements planned.

Through the MCH Services Program, the Title V MCH Program contracts with 112 LPHAs. Although many LPHAs experienced substantial turnover throughout the pandemic, the rate of LPHA workforce turnover had decreased in the earlier part of 2022. However, the turnover rate has increased again over the last couple of months. MCH Services program staff provide MCH Orientations for new LPHA MCH Coordinators, including content covering core principles of public health, MCH competencies, Life Course Perspective, the Spectrum of Prevention, contract terms and deliverables, and available resources. Prior to the pandemic, MCH Services program staff provided approximately 8-10 orientations per fiscal year. In FY 2021, program staff provided 37 MCH Coordinator Orientations, and they have already provided 46 orientations so far in FY 2022. Program staff also provide ongoing technical assistance to the LPHAs on the MCH Services contract and work plan, MCH initiatives/activities, and broad public health and public health nursing topics. LPHA requests for technical assistance have significantly increased related to and due to the COVID-19 pandemic and high rates of staff turnover.

In an effort to “refuel” and encourage local public health partners to continue the necessary and good work they aspire to do, the Title V MCH Program partnered with the MCH Services Program in August 2021, to provide the virtual motivational presentation, *“How to Refresh, Refuel and Boost Your Resilience When Your Tank Is Empty.”* The focus of the presentation was resiliency and self-care in a practical and applicable manner. 119 local public health partners attended the virtual event, and feedback from attendees included comments such as:

- *“Thank you for that last week---it was uplifting and a few of us in the office were able to huddle up around my computer and enjoy it! It brought some joy and peace to my life.”*
- *“We loved the presentation. You were spot on! The speaker was motivating and right on target. Exactly what everyone needed to hear! I was excited to hear it, and it didn’t disappoint! Thank you for making this happen!”*
- *“Wow, that was powerful! My bucket is filled.”*

Several local partners have shared they would like to see more of this type of workforce support in the future, as they have realized if they don’t take care of themselves in some capacity, it not only impacts them personally but also impacts their families, their work, and teams the people they serve. In an effort to continue providing support to the LPHA workforce, specifically focusing on mental health, the Title V MCH Program and MCH Services Program will host a one-hour virtual professional development presentation and present Badge Buddies to LPHA staff. Badge Buddy is a quick reference card that can be attached to the employee ID. It provides a list of signs that a team

member who is struggling emotionally and/or mentally may exhibit and what to look for as a supervisor or peer. The backside lists resources and phone numbers so team members can quickly and effectively provide support even if they are not a mental health professional. Badge Buddy is a product of the Break the Stigma: Mental Health Matters initiative, developed by Class #6 of the State of Missouri Leadership Academy to address prioritizing wellness surrounding mental health in the workplace for State of Missouri Employees. The DHSS Office of Human Resources provided Badge Buddies to all DHSS team members in 2022. The motivational presentation is scheduled for August 2022, and the presenter is an award-winning Medical Doctor and internationally recognized expert in stress management, burnout prevention and human resilience. The presentation will focus on managing stress and burnout and increasing resilience while thriving at work and in life. After the completion of the meeting, a LPHA Badge Buddy Request Form will be sent via email to all LPHAs, allowing them to request Badge Buddies for team members.

In January 2022, eight LPHA networking meetings, organized by priority MCH issue (PHI), were hosted by the MCH Services Program. The sessions featured presentations from speakers whose programs and resources directly related to the PHI, followed by a networking session to allow participants to share what is working, where they feel stuck, and what steps can be taken to move their MCH work forward. The PHI discussion topics and attendance included:

- Access to Oral Health Care Services for Children; 22 participants.
- Coordinated, comprehensive and ongoing health care services for children with and without special health care needs; 51 participants.
- Injury Prevention - Motor Vehicle Safety; 20 participants.
- Improved Pre-Conception, Prenatal, and Postpartum Health Care Services for Women of Childbearing Age; 28 participants.
- Injury Prevention - Child Abuse/Neglect; 14 participants.
- Reducing Obesity among Children and Adolescents; 20 participants.
- Promoting safe sleep practices among newborns to reduce sleep-related infant deaths; 13 participants.
- Promoting Protective Factors for Youth and Families; 29 participants.

In July 2022, the MCH Services Program partnered with MOKidsFirst to bring the Stewards of Children child abuse and neglect prevention training to local public health partners. The training uses real people and real stories to show how to protect children and is based on the framework of The 5 Steps to Protecting Children: Learn the Facts, Minimize Opportunity, Talk About It, Recognize the Signs, and React Responsibly. 64 LPHA staff attended the training. Breakout discussion sessions, grouped by priority MCH issues, were held after the training, allowing participants to share what is working well, where they feel stuck, and ways they can move forward using the training in their work with the MCH population.

The MCH Services Program partnered with the University of Missouri Extension to provide virtual Mental Health First Aid trainings to LPHA partners in September 2022. The MCH Services Program leveraged grant funding through the University to provide the trainings free of charge.

III.E.2.b.ii. Family Partnership

The Title V Program continues to develop relationships and engage with community members, parents, families, and organizations serving families to address the priorities and implement the strategies in the FFY 2021-2025 State Action Plan. As part of the statewide Five-Year MCH Needs Assessment completed in 2020, focus groups were held across Missouri to solicit feedback on the following topics: ability to access health insurance and insurance adequacy; ability to access care and care adequacy; barriers to and facilitators of good health; community and social issues; transportation; health literacy; mental health; substance use; and others. The social determinants of health inequities was a pervasive theme throughout the focus group discussions, and the need to intentionally promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities was identified as an overarching principle to be applied across all priorities, performance measures and strategies in the FFY 2021-2025 State Action Plan. Although the COVID-19 pandemic temporarily interrupted plans for more active and diverse partnership with families and family-led organizations, the Title V program remains committed to engaging with families at all levels and in all aspects of the FFY 2021-2025 State Action Plan.

Special Health Care Needs Family Partnership

The Special Health Care Needs (SHCN) Family Partnership strives to enhance the lives of individuals and families impacted by special health care needs, providing resources and information to empower families to live a good life. The Family Partnership hosts events to benefit families through development of leadership skills, networking among peers, and staying current with trends and issues regarding special health care needs. The Family Partnership includes individuals with special health care needs as well as parents, legal guardians, or siblings. SHCN utilizes information from the Family Partnership to enhance the relationship among SHCN and the individuals and families it serves. This includes seeking input from Family Partnership to ensure the family perspective is integrated in SHCN publications, educational/outreach materials, and the annual block grant application proposed use of funds. Family Partners are parents of individuals with special health care needs and provide information and peer support to family members. In addition to assisting families, the Family Partners plan, schedule, and facilitate all Family Partnership meetings, including the Family Partnership Parent and Caregiver Retreat. This ensures Family Partnership events are led by families for families. The Retreat provides an opportunity for families to network with one another, discover resources to assist their family, enrich their leadership and partnering skills, and plan a vision for their family's future. The Retreat also provides the opportunity for family input on various activities, such as the development of SHCN materials related to medical home and the Title V Five-Year Needs Assessment. Though the Retreat has not been held in recent years due to the COVID -19 pandemic, the intent is to hold Retreats again in the future.

Each Family Partner is well equipped to help explore options and solutions in the following topic areas: Daily Life - What your family members do as part of everyday life: school, employment, volunteering, communication routines, and life skills; Social and Spirituality- Building friendships and relationships, leisure activities, personal networks and faith community; Community Living - Housing and living options, community access, transportation and home adaptations; Advocacy and Self-Determination – Developing advocacy skills, transition planning for the future, fostering independence and interdependence; Healthy Living - Managing health care and staying well: medical needs, exercise, therapy services, locating physicians and specialists, medical home; Safety and Security - Emergency planning, well-being, community support, guardianship options, legal concerns; Services and Supports - Using an array of integrated supports to achieve a good life, including mentor programs. The objectives of the Family Partnership are to provide families with the opportunity to offer each other support and information; give families the opportunity to provide input based on lived experience on the needs of individuals with special health care needs; and build public and community awareness of the unique needs and issues facing families of individuals with special health care needs.

Since 2015, SHCN has employed four hourly and intermittent Family Partners who are parents of children and youth with special health care needs. Family Partners serve as the parent representatives for SHCN. In addition, Family Partners provide information, training, technical assistance, and peer support to families of children and youth with special health care needs so they can make informed decisions about their children's health and serve as family leaders at the state level to improve services for children and youth with special health care needs. Family Partners receive training on Bureau programs and services and often work with other DHSS program staff. They developed an improved referral process to enhance communication and efficiency of referrals made to Family Partners from Service Coordinators. This internal electronic referral form includes: referring staff member information; participant and family demographics; a section to document the need, diagnosis, and other concerns identified at the time of referral; and a section for Family Partners to document follow-up actions, including informing the referring Service Coordinator of the outcome. Family Partners are also able to provide education to Service Coordinators on the services provided by Family Partnership and the unique issues facing families of children and youth with special health care needs. A streamlined referral process and education to Service Coordinators increases the number of referrals for SHCN families to Family Partnership. In collaboration with the Newborn Hearing Screening Program, SHCN expanded the Family Partnership by adding two additional Family Partners. These Family Partner positions are funded by the Health Resources and Services Administration Universal Newborn Hearing Screening and Intervention Program grant and specifically serve families of children who are deaf or hard of hearing. Additional information regarding the SHCN Family Partnership can be found in the State Action Plan for Children with Special Health Care Needs.

Missouri Parent Advisory Council (PAC)

The Missouri PAC provides in-person trainings, typically held in the spring and fall, for specific projects that members may become involved with at the state level. Training may also include attending out-of-state conferences that would benefit both the individual member and the PAC as a whole. PAC members receive training in Strengthening Families™ and the Protective Factors Framework through Strong Parents, Stable Children: Building Protective Factors to Strengthen Families training and facilitative leadership training. Many members have experience and training in how to host and implement Parent Cafés and are participating in these within their communities. One member is a trained facilitator in the “Darkness to Light: Stewards of Children” prevention of child sexual abuse training. PAC members work in their communities to bring issues facing local families to a higher level to improve access to services and increase family engagement within programs. One PAC member provided food and supplies to those in need by utilizing her 501©3 organization. For more information, please go to <https://earlyconnections.mo.gov/getconnected/parent-advisory-council>. Due to the COVID-19 pandemic, PAC meetings have been held virtually since 2020. The Department of Elementary and Secondary Education is the lead in Missouri for the Preschool Development Grant: Birth to five (PDG B-5), they have utilized this funding to further family engagement and leadership. PDG B-5 funding was used to develop a PAC facilitation toolkit and recruitment guide. PAC members and others across the state can use these resources to engage families and develop leaders.

Home Visiting Family Engagement

The MCH funded Home Visiting programs have a formalized three-tiered continuous quality improvement (CQI) process in which family engagement is an integral part. One or more current or former home visiting family participant(s) are required to be included as member(s) of each Level 1 CQI Team. Level 1 meetings are face-to-face quarterly meetings held by each individual Local Implementing Agency (LIA) implementing a specific home visiting model. It is the fundamental base at which changes to improve services to families occur. As of October 2019, every LIA had successfully incorporated the inclusion of family participant(s) as team member(s) who are recognized as a vital element in helping the LIAs determine what processes work and what needs adapting to implement and achieve CQI. Having successfully achieved family engagement in CQI efforts at Level 1, the Missouri Home Visiting CQI Handbook was formally revised in October 2019 to fully outline the required inclusion of families at Level 1, and the mechanism to include families as representatives at Level 2 as leadership is developed. To date,

though success has been achieved in the inclusion of family members at Level 1, there has not yet been time or consistency with family participants to raise their presence to Level 2. This remains a goal for Missouri home visiting programs. An ongoing challenge is that families have varying levels of commitment once they are no longer enrolled, and their circumstances change often even when currently enrolled. The families served are often in crisis, so the turnover of families is high for some agencies. In July 2020, the Home Visiting Program made a formal invitation to the PAC for one or more PAC members to join the state Level 3 team. This resulted in a response from a PAC member interested in joining, but circumstances related to the COVID-19 pandemic resulted in cancellation and rescheduling of the Level 3 Meeting, preventing the PAC member from participating. The invitation was re-extended in July 2021.

Since 2012, Missouri has been obtaining family input regarding their experience with the LIAs and the home visiting services they receive through an annual survey. The results of this survey are returned unopened from each LIA to the Home Visiting Program, analyzed, and then shared in aggregate form back to the submitting LIA. These results can identify trends that may need to be addressed with TA from the Home Visiting Program to the LIAs. Due to the transition to virtual home visits during the COVID-19 pandemic, the Home Visiting Program attempted to obtain this annual survey information through surveys mailed directly to all enrolled participants. Home Visitors were asked to remind families during virtual home visits to complete and return the survey. This method did not yield a viable response rate needed to develop an annual report for FFY20. Once home visitors are able to provide in-person home visits, surveys will be given to families by the home visitor and completed during the home visit.

Newborn Screening Family Engagement

The Newborn Screening team produces a quarterly newsletter called *Behind the Screens* that is distributed to over 250 healthcare providers. Each edition includes a patient spotlight that features a child that has been diagnosed through newborn screening. Parents are invited to share their experiences of how newborn screening has impacted their child's life. Through their stories, parents are able to provide personal feedback to the frontline healthcare workers who are collecting the screens, which reinforces the vital role they have in improving the lives of Missouri babies.

On December 1, 2021, the Missouri Newborn Screening Program launched the implementation phase to screen all Missouri newborns for adrenoleukodystrophy (ALD), ensuring all newborn specimens received by the Missouri State Public Health Laboratory are screened for ALD. ALD is a genetic disease that most severely affects males. This disease mainly affects the nervous system and the adrenal glands, and often causes progressive loss of the myelin sheath, which acts as an insulator and surrounds the nerves in the brain and spinal cord. This can cause a variety of neurological problems including cognitive, mobility, and sensory issues. ALD may also cause a deficiency of certain hormones due to damage to the adrenal glands. This **adrenal insufficiency** may cause weakness, weight loss, skin changes, vomiting, and coma. If left untreated, the severe form of ALD can lead to critical and irreversible disabilities that can ultimately lead to death. Early diagnosis through newborn screening allows for proactive care, consistent monitoring, and lifesaving treatment. The Missouri Newborn Screening Program established an ALD Task Force to provide expert guidance and feedback during the implementation phase to ensure a comprehensive, evidence-based, and family centric approach to screening. In addition to clinical specialists, laboratory staff, and follow-up staff, two parent advocates were invited to participate in the ALD Task Force. These two individuals have been invaluable in the development of educational materials, review of resources, and ensuring the family perspective is kept in the forefront.

The Newborn Hearing Screening Follow-up Coordinator from the Bureau of Genetics and Healthy Childhood Newborn Hearing Screening Program together with a Family Partner from the Bureau of Special Health Care Needs Family Partnership were chosen from a large pool of applicants to participate in the "Impact of Family Support and

Engagement Learning Community (IFSE-LC)” developed and led by the National Center for Hearing Assessment and Management and The Family Leadership in Language and Learning Center. They will participate with six other state programs and their corresponding family-based organizations to learn the key domains of family support, survey methods, and evaluation processes. The IFSE-LC will create a survey tool to assess the impact of family support to families with infants and children newly diagnosed with hearing loss and evaluate how family support is making a difference, as well as identify areas of improvement.

Family Partnership through Contracts

The Child Care Health Consultation (CCHC) Program encourages family engagement via program services. Parents/guardians of children in child care are invited to attend children’s health promotions and participate in health and safety trainings provided to child care providers. Content for health promotions works to include handouts and other resources of information for children to share with parents at home, to help improve parent/guardian health and safety knowledge for their child outside of the child care setting. Frequently, training for child care providers includes how to communicate and work closely with families of the children they care for, promotes resilience in children and families, and provides resources on these topics for child care providers and for distribution to parents/guardians. Parents/guardians are also invited to participate in specialized consultation(s) alongside the child care provider(s) when the purpose of the consultation pertains to their child. CCHC Program services may also provide opportunities for parent/guardian involvement for the development of Individualized Health Plans (IHPs), referrals to outside resources, such as MO Health Net, developmental screening, and WIC, and notification of the child not being up to date on routine immunizations, and to create dialog between the child care provider, the parent/guardian, and the child’s health care provider, as necessary. Child Care Health Consultants (CCHCs) work with child care providers to develop policies, implement procedures, and provide trainings that promote optimal family partnerships for the health and safety of children and in child care. CCHCs also assist child care providers in the development of Individualized Health Plans (IHPs) and referrals to outside resources such as WIC, developmental screening, MO HealthNet, and other resources specific to their communities as needs are identified.

The MCH Services Program contracts with 111 LPHAs whose efforts include addressing risk and protective factors that influence health disparities within families and communities through the Life Course Perspective. The MCH Services contracts require the identification of strengths, weaknesses, and needs of the community’s MCH population and encourage the engagement of families in programming efforts, local MCH needs assessments and work plan development, implementation and outcome evaluation.

The Inclusion Services (IS) project intertwines family engagement through values, policies, and practices that support the right of every child and his or her family, regardless of ability, to participate in a broad range of activities as members of a child care program, community, and society. The desired result of inclusive experiences for children with or without disabilities and their families include a sense of belonging and membership, positive social interactions and friendships, and development and learning to reach their full potential. The Inclusion Specialist provides outreach, technical assistance, and training to child care professionals and families of children with special needs. They provide Inclusion training and training with a social-emotional component based on the research-based Pyramid and Conscious Discipline models. They provide program outreach by promoting inclusion services to facilities licensed, regulated or registered by the Department and community awareness through newsletters, calendars, websites, and other media. They promote inclusion services at community events such as child care conferences and through local agencies that support and assist with placement of children in child care settings through phone calls, emails, and in person contact.

III.E.2.b.iii. MCH Data Capacity

III.E.2.b.iii.a. MCH Epidemiology Workforce

MCH Data Capacity & Epidemiology Workforce

Missouri DHSS has a great deal of MCH epidemiology capacity built into its organizational structure. All components, including programmatic and data, which impact MCH practice in the state are organized within the Division of Community and Public Health (DCPH). The integration of data collection, analysis and program services provides great flexibility in terms of the flow of information and information exchange with minimal challenges. The integrated DCPH organizational structure can be hailed as one of Missouri's strengths in terms of cross-sectional partnership building and collaboration.

In addition to core MCH programs, health promotion and chronic disease prevention programs, communicable disease prevention programs, WIC and nutrition services, and the Center for Local Public Health Services are housed within DCPH, as is the Office of the State Epidemiologist. The Office of Primary Care and Rural Health, Office of Minority Health, Office of Dental Health, Office on Women's Health, and the Bureau of Genetics and Healthy Childhood are also located within the DCPH. The centralized location of all these units catering to Missouri's MCH populations and receiving support from the Missouri Title V agency within one Division underscores the need for a MCH epidemiology workforce that can provide data and analytical support in a coordinated manner.

The Section of Epidemiology for Public Health Practice (EPHP) is within the DCPH and houses the core MCH epidemiology and data analysis capacity of the Division. The Office of Epidemiology (OOE), which includes the MCH and Chronic Disease epidemiology teams, is the Division's principal link between information science and public health, conducting much of the Division's secondary data analysis and supporting program evaluation, planning, survey design and interpretation, and data dissemination. The OOE works closely with the Bureau of Health Care Analysis and Data Dissemination (BHCADD) and the Bureau of Vital Statistics (BVS) to perform primary data collection, validation, analysis and dissemination. The MCH epidemiology team is centrally located to provide data and analytical support to a wide variety of MCH programs across the Division and Department. In addition to the team lead, a Senior Epidemiologist, the MCH Epidemiology unit within the OOE has several epidemiologists and research analysts with the capacity and access to analyze data from a variety of population-based surveys and data systems, such as the Behavioral Risk Factor Surveillance System (BRFSS), the Pregnancy Risk Assessment Monitoring System (PRAMS), National Violent Death Reporting System (NVDRS), vital statistics, reportable conditions data, and program specific data.

Missouri's Title V MCH Block Grant provides funding support for 8.055 full-time equivalent (FTE) positions for data, analytical, and dissemination needs within EPHP, with an additional FTE supported through the SSDI grant. The FTEs include 0.5 FTE for an internship to assist with MCH epidemiology workforce development. Although a significant portion of the epidemiology workforce was redirected to assist with COVID-19 pandemic response efforts, and EPHP experienced significant staff turnover during the pandemic, epidemiology staff have been reassigned back to regular functions, and successful recruitment efforts are filling vacant positions, resulting in a revived epidemiology workforce.

III.E.2.b.iii.b. State Systems Development Initiative (SSDI)

The Missouri State Systems Development Initiative (SSDI) project serves three core purposes:

1. Provide valuable support to identify and integrate Title V performance measures with other data sources as outlined in the five year needs assessment;
2. Work to enhance the availability and timeliness of comprehensive longitudinal data by supporting improved data reporting procedures and linkages; and
3. Enhance/expand the utility of the minimum/core datasets (M/CDS) for MCH program planning and resource allocation.

Missouri's SSDI project is located within the Office of Epidemiology. The strategic organization of the SSDI project with other data collection programs such as vital statistics, chronic disease epidemiology, MCH epidemiology, reportable diseases, and the Patient Abstract System, positions MO advantageously to compile and report on data elements required for the M/CDS indicators. The vast majority of data elements required for M/CDS are already gathered for the existing Title V MCH Block Grant application in the form of performance measures, health status indicators, and health system capacity indicators. Compiling these data elements for M/CDS is a logical extension of the existing efforts. Data elements required for the M/CDS will be collected from both state and national data sources.

The MO SSDI project provides data support for the Title V MCH Block Grant annual application and both the five-year and ongoing MCH needs assessment processes. SSDI project staff continue to work closely with local public health agencies (LPHAs) to provide data and assist with development of effective work plans to address ongoing challenges affecting maternal and child health, including providing data to assess social determinants of health, smoking among women of childbearing age, and healthcare access.

MO SSDI project staff have been working with the birth vital statistics team within the Bureau of Vital Statistics to develop a longitudinal dataset that links subsequent births to the same mother. The goal of this dataset is to enhance public health programs' capacity to understand the long-term impacts of socioeconomic and/or health improvement activities – for example, a client may enroll in a home visiting program too late in pregnancy to reduce the risk factors for a pre-term birth during that pregnancy but may see reduced risk of pre-term birth among future children. The purpose of the subsequent births dataset is to move investigations of longitudinal program impacts from the realm of anecdote to data by developing a dataset large enough to permit powerful, high-level analyses.

The SSDI project continues to provide valuable support to identify and integrate Title V performance measures with other data sources, including vital statistics, Pregnancy Risk Assessment Monitoring System (PRAMS), the MO Child Health Assessment Program Survey (MoCHAPS), and home visiting programs. The MO SSDI project has also contributed data to enhance the ability of LPHAs receiving Title V MCH funding to conduct local- and regional-level MCH needs assessments. The project continues to support population-based surveillance systems, such as PRAMS and MoCHAPS, and other MCH programs. Because it integrates so many different data systems, the SSDI project continues to assist with the MCH needs assessment by developing fact sheets using data pulled from a variety of sources, including PRAMS, MoCHAPS, the Youth Risk Behavior Survey, BRFSS, and vital statistics. SSDI project staff continue to enhance the DHSS' ability to accurately capture the circumstances surrounding severe maternal morbidity (SMM), including updating programming code and improving the quality of and methods for linking cases of SMM to birth and death records.

III.E.2.b.iii.c. Other MCH Data Capacity Efforts

County Level Study (CLS)

The Office of Epidemiology (OOE) is currently collaborating with the University of Missouri-Columbia Health and Behavioral Risk Research Center (HBRRC) to conduct the 2022 Missouri County-level Study (CLS). The last CLS in Missouri was done in 2016 and was well received across the state because of its ability to provide county level data on a variety of chronic disease and MCH indicators.

The Missouri Behavioral Risk Factor Surveillance System (BRFSS) has been in existence for over 35 years and is the primary surveillance system that combines demographic information as well as social and environmental factors (e.g. health care access) with information on chronic diseases (e.g. diabetes) or other related health conditions (e.g. obesity) and behaviors associated with health outcomes (e.g. smoking or physical activity). The MO BRFSS survey is conducted annually with partial funding from the Centers for Disease Control and Prevention (CDC). One of the major limitations of the MO BRFSS is that the current budget can only fund approximately 7,000 surveys per year. This sample size is insufficient to address county-level health questions. The MO BRFSS program recommends enhancing data collection by adding up to 10,000 additional survey responses per year.

The CLS is modelled after the MO BRFSS. Earlier versions of this study were successfully conducted in 2007, 2011, and 2016 using funding sources that are no longer available. Since many public health interventions are implemented at county or sub-county levels, an estimated 50,000 surveys are required to provide detailed data to inform prevention and planning at the local level. The CLS is similar to the MO BRFSS in terms of following the CDC's best practices for sampling, data collection, and weighting methodologies; however, the Department of Health and Senior Services (DHSS) has greater control over the survey design and the opportunity to collect a sample size sufficient for county- and sub-county-level analyses. The intended target of the study is approximately 50,000 Missouri adults ages 18 and older, distributed across all 114 Missouri counties and the City of St. Louis. The interviews will be conducted via randomly selected landline and cell telephone numbers using a standard questionnaire that is developed in collaboration with internal and external public health partners. The questions will be tailored to address data collection needs surrounding COVID-19.

Collecting comprehensive, granular information through state and local needs assessments enables data-driven intervention planning and allocation of resources to more effectively target populations for public health interventions.

Pregnancy Risk Assessment Monitoring System (PRAMS) – Social Determinants of Health Supplement

The Council of State and Territorial Epidemiologists (CSTE) partnered with the CDC-Division of Reproductive Health (DRH) to provide technical assistance to state, local and territorial public health agencies for the implementation of routine population-based data collection to inform public health's understanding of the effects of Social Determinants of Health (SDoH) on the experiences and attitudes of pregnant and recently postpartum women and their infants. The project supports jurisdictions to collect SDoH information about participants' experiences with housing instability, food and transportation insecurity, barriers to mental health access, and race or ethnic discrimination among women with a recent live birth before, during and immediately after pregnancy. Participating jurisdictions have implemented the SDoH questionnaire supplement as part of the Pregnancy Risk Assessment Monitoring System (PRAMS) to collect population-based data on the impact of SDoH on pregnant and postpartum women and infants. Missouri PRAMS has been implementing the SDoH Supplement and collecting data since May 2022. Data collection will continue for 11 months through March 2023.

Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET)

Missouri receives funding from the CDC to participate in Surveillance for Emerging Threats to Mothers and Babies Network (SET-NET) through the Epidemiology and Laboratory Capacity for Prevention and Control of Emerging Infectious Diseases (ELC) cooperative agreement. SET-NET supports states and other jurisdictions to adapt and

expand existing surveillance systems to monitor for emerging infectious diseases and health threats during or around the time of pregnancy through the child's first year of life. SET-NET collects data on mothers, and infants and the impact of various health threats including Zika, Hepatitis C, Congenital Syphilis, and COVID-19. SET-NET also tracks birth defects, developmental problems, and other disabilities as these children age. Epidemiologists use these data to:

- Monitor and improve the health of pregnant people and infants;
- Link families to medical and social services to get recommended care;
- Strengthen laboratory and clinical testing to find emerging health threats quickly; and
- Ensure public health is ready and prepared to meet the needs of pregnant people and infants during emergencies.

This surveillance builds upon the US Zika Pregnancy and Infant Registry. The Registry collected health information on pregnant people and their infants with laboratory evidence of Zika infection during pregnancy. A key part of this unique surveillance is the ability to find exposures during pregnancy and link them with health outcomes of pregnant people and infants. This innovative and nimble approach enables CDC and state, local and territorial health departments to monitor exposures of concern during pregnancy and collect follow-up data on affected infants over time.

Missouri is currently only funded to collect and report information related to COVID-19 and pregnancy. For COVID-19 surveillance, Missouri identifies pregnancies of interest and collects necessary information through linking COVID-19 testing data with other data sources including: birth certificates, fetal death certificates, death certificates, COVID-19 vaccination data, and the Patient Abstract System (PAS). Key COVID-19 surveillance questions include:

demographics and risk factors of pregnant people with COVID-19, timing of illness onset, presence of symptoms, severity of illness, reinfections, genetic variants (e.g. Delta), complications with pregnancy, birth/neonatal outcomes (such as infant death, low birth weight, and preterm births), infant COVID-19 testing status, severity of post-natal infection, infection and reinfection in infants, infant growth patterns, and other concerns.

In order to be considered a record of interest for mother-baby surveillance of COVID-19, the mother must be a Missouri resident and have at least one lab-confirmed positive SARS-CoV-2 RNA test result at any point during pregnancy up to and including the day of delivery. The positive test result must have occurred between January 20, 2020 and December 31, 2021.

Levels of Care Assessment Tool (LOCATe) Process Improvements

The CDC developed the Levels of Care Assessment Tool (LOCATe) to help states and other jurisdictions create a standardized assessment of levels of maternal and neonatal care. Assessing these levels using a consistent methodology allows jurisdictions to ensure pregnant women and their babies are receiving risk-appropriate care. Missouri initially implemented this tool as a paper-based survey. In FFYs 2020 and 2021, the program worked to design a more efficient process to improve efficiency and add features to ensure a good user experience and high data quality.

The program sought to design a more efficient electronic process. The DHSS received a REDCap-based version of LOCATe from CDC. This survey was built to include a variety of features to ensure a good user experience and high data quality. This included setting most questions as required fields, having minimal free text fields, and incorporating skip patterns to bypass questions that are not applicable. It also includes questions asking the respondent what level of care they believe their facility provides. This allows programs to identify discrepancies between the facility's self-reported status and their LOCATe result. If the self-report does not match the LOCATe results, the facility is provided additional information on why they received a certain score when the results are processed. After the surveys have been received from birthing facilities, the de-identified file is shared with CDC. CDC performs the analysis, and then the program puts the results into REDCap. The results page triggers email alerts that notify the facility of their result.

The email alerts were designed to mimic the formal, mailed letters that the program previously sent.

Transitioning to a paperless process allowed the program to improve the user experience while reducing the costs of staff time, printing, and mailing. It also improved data quality and allowed for more timely analysis and reporting. DHSS staff time required for data entry was eliminated. The amount of time required for respondents did not change between paper and electronic reporting.

III.E.2.b.iv. MCH Emergency Planning and Preparedness

The MCH population has unique needs during an emergency, and Missouri has worked to enhance emergency preparedness planning and response activities to assure MCH population needs are considered in state, regional, and local planning. The MCH Director serves as a branch manager and is part of the Planning Team in the DHSS Emergency Response Center (ERC). Many Title V MCH Program team members serve in the DHSS ERC, including serving on the Local Public Health Management team. The State Emergency Operations Plan (SEOP), reviewed annually, considers a variety of vulnerable populations, including at-risk and medically vulnerable women, infants, and children, in planning elements. Missouri actively includes vulnerable populations in exercises and has sponsored multiple statewide conferences focused on emergency planning issues specific to children and families, such as reunification and pediatric medical surge planning. Missouri maintains an interdisciplinary Children and Youth in Disasters (CYD) Subcommittee of the statewide Access and Functional Needs Committee, with six standing work groups addressing needs across the systems where children live and receive care and support and focused on several key aspects of children's environments including: public health/medical disaster planning; schools; child care; foster care and congregate care; children's mental health; and emergency services (e.g., sheltering, feeding).

Work began in early 2020 to systematically integrate MCH knowledge, expertise, and populations into our emergency preparedness risk assessment, training, and exercise planning processes, and the state, regional, and local emergency operations plans. Although the COVID-19 pandemic interrupted formal integration of MCH into Emergency Preparedness and Response (EPR) processes, the pandemic presented opportunities to strengthen existing and build new partnerships between Title V, EPR and MCH programs across state agencies, local public health partners, and community organizations. Lessons learned through COVID-19 response will enhance the work started to Build EPR capacity for maternal and infant and increase capacity to adequately assess and respond to MCH needs in a future disaster or public health emergency. Knowledge gained will inform Title V MCH Program participation in future development of EPR training, communication plans and tools/strategies to enhance statewide preparedness for addressing potential short- and long-term impacts of disasters and emerging threats on the MCH population.

Addressing the needs of Missouri's children and youth with special health care needs (CYSHCN) and their families presents unique challenges and requires special considerations in EPR. Missouri is a largely rural state, with greater population concentrations surrounding the larger urban areas. Comprehensively meeting the needs of CYSHCN and their families in rural areas is more difficult due to transportation barriers and limited access to providers with specialized experience in treating complicated health issues. During times of emergency, MCH team members work to ensure CYSHCN and their families continue to receive high quality services in their local communities and have help to identify resources for additional support. Additional information regarding EPR for CYSHCN can be found in the CYSHCN Population Domain narratives.

Missouri has a variety of MCH surveillance systems that have the ability and flexibility to collect timely data during public health emergencies. The following is an overview of the various MCH surveillance systems that have the ability to gather data with respect to emergency preparedness and response among Missouri's MCH populations:

1. National Vital Statistics System (NVSS) –Birth and death certificate data is compiled by the Missouri vital statistics team in conjunction with CDC NCHS to assign death codes and compile an annual birth file for pregnancy outcomes. The data can also be compiled monthly to provide real time estimates for adverse pregnancy and neonatal outcomes.
2. National Syndromic Surveillance Program (NSSP) – ESSENCE, Missouri's syndromic surveillance program, collects real time data from hospitals across the state, including information on chief complaint and ER visits. ESSENCE continues to be a critical resource for timely public health action for a range of issues including but not limited to suicide attempts, COVID like illness, opioid overdose visits and ER visits during natural

disasters.

3. **Pregnancy Risk Assessment Monitoring System (PRAMS)** – Missouri PRAMS continues to be a key MCH surveillance system during public health emergencies, such as the COVID-19, H1N1 and opioid epidemics. The program will be adding new questions to the survey to capture data about emergency preparedness activities for families with infants.
4. **Behavioral Risk Factor Surveillance System (BRFSS)** – The BRFSS is the nation’s premier system of health-related telephone surveys that collect state data about U.S. residents regarding their health-related risk behaviors, chronic health conditions, and use of preventive services. BRFSS is a population-based surveillance system that has the ability to add modules, such as the COVID-19 module, during public health emergencies for assessment of emergency preparedness among all Missourians, including MCH populations.
5. **Reportable Disease Data Collection System (EpiTrax)** – The EpiTrax system collects and compiles COVID-19 case data on a real time basis, and the data is disseminated to the public on a daily basis through dashboards.
6. **Show Me Vax (SMV) Data Application** – Show Me Vax collects vaccine data in Missouri. While it is not mandated to report vaccines in Missouri, it is mandatory for providers to report COVID-19 vaccine uptake. COVID-19 vaccine data is available in real time, is compiled on a daily basis and is made available to the public through dashboards.

COVID-19 Response

Throughout the COVID-19 pandemic, the Title V MCH Program was relied on to provide leadership and support in delivering critical MCH services and assisting local communities to respond to emerging threats and needs.

Title V coordinated with MCH partners to develop and implement EPR plans to address MCH population needs.

Highlights of Title V supported COVID-19 response activities are summarized below.

- A majority of program staff supported by Title V funding provided ongoing assistance with state COVID-19 pandemic response efforts such as: participating in operational briefings with state and local leaders and partners; manning the DHSS ERC and the state emergency operations center; conducting data entry and processing; working the EpiTrax Help Desk; test result notifications/sorting; case investigations/contact tracing; training; community testing and vaccination administration; community education and engagement; provision of accurate and reliable information to partners, health care providers, parent networks, etc.; partnerships with other state agencies, medical providers, and health care organizations to help educate the MCH population about COVID-19; support for local emergency preparedness efforts to represent the needs of the MCH population; and MCH epidemiology support, including setting up and maintaining public facing COVID-19 dashboards.
- SHCN team members collaborated with MO HealthNet on Medicaid waivers and state plan amendments and provided one-on-one education with families and providers on COVID-19 precautions, testing sites, vaccinations, resources, etc.
- The Women’s Health Initiative Program provided weekly women’s health listserve updates and technical assistance to subcontractors on best practices for virtual engagement and transitioning their work to virtual settings.
- The State School Nurse Consultant provided ongoing support and guidance to schools and school nurses, including hosting virtual learning opportunities for school nurses to assist with implementing on-site COVID testing and best practices in schools, developing guidance for schools, participating on the Hub team for the COVID and Kids ECHO, and responding to requests for guidance and best practices on pivoting from in-person to virtual or “front porch” school nursing.
- At the request of the Association of State and Territorial Dental Directors, the Office of Dental Health contributed to the creation of a toolkit for schools on how to respond to the pandemic and manage, coordinate

and provide a school-based preventive oral health services program.

- Title V funded local implementing agencies (LIAs) transitioned to providing virtual or tele-home visiting (HV) services, engaging families in HV services within the limits of stay at home orders and social distancing recommendations. LIAs supported HV families in the following ways:
 - Healthy Families America (HFA) LIAs used local diaper banks for supplies and referred families to local resources for support. Staff helped families complete forms for utility assistance. Diaper and wipes were delivered through no contact delivery at family homes, with additional community resource information included. Resources were also texted to families.
 - Nurse Family Partnership (NFP) LIAs stayed connected with clients through tele-visits to provide services and ensure families had access to available community resources. Collaboration between agencies was particularly apparent in the St. Louis region where weekly virtual webinars were sponsored by Generate Health to allow presentations by community resource agencies, sharing their contact information to agencies serving families. Diapers and wipes were distributed to enrolled moms by either no contact home drop-off or by pick up by the families.
 - Information was sent out in the private DHSS HV Weekly Update email to LIAs regarding free data and minutes from SafeLink Wireless for families receiving unemployment benefits.
 - NFP's national office partnered with Verizon cellular to provide free cell phones with four months of data service for LIAs to order and distribute to clients to access resources, including healthcare providers and crisis hotlines. DHSS Title V and MIECHV grant supported NFP LIAs obtained and distributed over 60 free cell phones.
 - Webinars and additional resources for building protective factors were shared with LIAs, offering updated information specific to supporting families virtually during the COVID-19 pandemic.
 - The Title V supported NFP agency is based within the Southeast Health Hospital healthcare system, allowing NHVs the ability to assist pregnant and new moms in establishing and maintaining relationships with healthcare providers for preventive and routine healthcare for their children. When well-child visits were canceled due to COVID-19 restrictions, NHVs followed up with new moms to assure visits occurred when re-scheduling was possible. Completion of routine well-child visits is a DHSS Home Visiting Program performance measure.

The local public health system was significantly impacted by the COVID-19 pandemic, and regular day-to-day local public health agency (LPHA) operations were drastically decreased, and in some cases completely halted, to maximize local response capacity. In an effort to support the continually evolving needs of the LPHAs as they anticipated and responded to the significant impact of COVID-19 in their local communities, flexibilities in the expenditure of Title V funds through the MCH Services contract were allowed to support implementation of approved science-based approaches to respond to COVID-19 and address related MCH population needs. Expenditures were in accordance with state fiscal policies and regulations for MCH block grant funds and all other contract funding provisions. Local approaches and responses included: epidemiological activities related to outbreak investigation; educating public health partners, community agencies, medical providers, health care organizations, and the MCH population about COVID-19; working with local, regional, and/or state public health partners to assure the needs of the MCH population are prioritized and addressed appropriately; building infrastructure capacity to support COVID-19 response, including testing, case investigation and/or monitoring, vaccination, and related health services; provision of accurate information and community status updates; and community-wide educational communication and media campaigns.

The School Health Program (SHP) participated in coordinated COVID-19 response efforts to communicate practice recommendations and resource options. The SHP leveraged the established frameworks of Show-Me ECHO

(Extension for Community Healthcare Outcomes) to partner with the subject matter experts to develop and setup didactic learning opportunities for school nurses on COVID-19 and general infection control practices, as well as other prevalent chronic conditions including Autism, Asthma, and Trauma-Informed care. The SHP sponsored a series of focus group conversations with key stakeholders in school nursing across Missouri to identify successes, challenges, needs and barriers from the COVID-19 response in the school setting. From this work, the SHP also collected recommendations for improving response plans for infectious disease management among communities and partners to maintain student wellness and family health. The focus groups were followed by a series of interviews with agencies working with school health staff.

There has been a significant turnover of public health nurses in all settings, including local and state public health and school nursing. Title V MCH continues to work with state and Department leadership to address gaps in this critical public health profession to ensure capacity to adequately assess and respond to MCH population and program needs in future disasters or public health emergencies.

The COVID-19 pandemic highlighted and exacerbated systematic inequalities affecting vulnerable populations, especially communities of color. Related emerging needs in MCH such as: disruptions to routine maternal, infant, child, and adolescent health care, including routine scheduled immunizations; reductions in breastfeeding prevalence; shortages in child care providers; decreased access to infant formula and food; increased homelessness; and increased mental health needs, substance use and suicide, just to name a few, further elevated the importance of prioritizing the MCH population in EPR planning and activities. Along with continuation, evaluation and expansion of telehealth models, leveraging new and expanded partnerships, and enhancing MCH data collection, analysis, and observation capacity, these are some of the new MCH challenges to be addressed and opportunities to be explored.

III.E.2.b.v. Health Care Delivery System

III.E.2.b.v.a. Public and Private Partnerships

Collaborative Work with Federal, State & Non-Governmental Partners

Maternal/Infant Health

The Department of Health and Senior Services (DHSS) Title V MCH team members were involved in several efforts that have enhanced a systems approach to ensure access to quality health care and needed services for Missouri's MCH population. DHSS partners with several organizations serving Missouri's Bootheel counties to support the Rural Maternity Obstetrics Management Strategies (RMOMS) grant, which was awarded to Saint Francis Healthcare System in Cape Girardeau. The RMOMS grant seeks to support health care providers, hospitals, public health, and social support agencies to work together with communities to build on local resources to meet the health care needs of women and newborns and create a new model of service delivery.

Beginning in FFY 2022, the MCH Director and Maternal Mortality Coordinator were invited to participate in the Department of Social Services (DSS), MO HealthNet Division Maternal Health Coordination monthly meetings to establish a baseline understanding of existing activities to address maternal health priorities and collaborate regarding maternal health workgroups, projects, initiatives, etc. Additional information regarding Partnerships for Maternal/Infant Health can be found in the Women/Maternal Health Population Domain narratives.

Child/Adolescent Health

On August 28, 2021, nearly all early childhood programs across state government were consolidated in a single Office of Childhood (OoC) at the Department of Elementary and Secondary Education (DESE). DHSS Home Visiting (HV), Early Childhood, Safe Cribs, and Child Care Health Consultation (CCHC) programs, all of which receive Title V funding and contribute to the MCH State Action Plan, moved to the new OoC. To meet the authorizing legislation requirements of Section 509 of the Social Security Act, an interagency contract was developed between DHSS and DESE to establish: DHSS Title V MCH authority and oversight for Title V allocations to DESE and the programs receiving Title V funding; accountability measures and reporting requirements related to Title V funding allocations; and interagency MCH data sharing and reporting requirements. A MOU was executed between DHSS and the DESE Maternal, Infant and Early Childhood Home Visiting (MIECHV) Program to collaborate on programs and activities to improve maternal, infant, and child health outcomes.

DHSS has a MOU with DSS, DESE and the Children's Trust Fund (CTF) to facilitate exchange and use of information regarding incidences of child maltreatment and/or neglect among HV program clients to assess the degree to which families enrolled in HV have lower substantiated/called-in reports and whether the number of reports declines over time as clients work with their home visitors to develop parenting and resiliency skills. The MOU only collects data to comply with required MIECHV performance measure reporting for comparison between MIECHV, Title V funded HV programs, and CTF HV outcomes.

The State Dental Director plays an essential role in state oral health programs. DHSS has an agreement with DSS for the Dental Director position to be shared between both agencies. The Office of Dental Health (ODH) partners with the Missouri Coalition for Oral Health (MCOH), the Missouri Primary Care Association (MPCA) and the Missouri Dental Association (MDA) to promote oral health education among their constituents. The MCOH promotes oral health among the general public through social media and other types of public-facing educational opportunities. The MPCA works with the Federally Qualified Health Centers (FQHCs) to provide training to dental personnel and dental care to the Medicaid population. The MDA is integral in increasing Medicaid rates and innovative ways to deliver dental care to the underserved. The MDA also coordinates the annual Missouri Mission of Mercy (MOMOM) to provide free dental care in regions of Missouri.

The School Health Program (SHP) partners with the American Academy of Pediatrics (AAP) to support school nurses to be responsive to factors contributing to student health. This includes collaborating to update modules in the TEAMS (Training, Education, Assistance, Mentoring, Support) framework to address environmental policies and practices related to infection control in the school setting and engaging with the Missouri Chapter of the AAP to sponsor conferences and training opportunities for school nurses and local physicians to enhance their abilities in working with students and families. The State School Nurse Consultant serves as a HUB team member for the Children with Autism and the COVID-19 and Kids ECHOs and is a member of the advisory committees for the Medicaid in Schools Program, the Center of Safe Schools, the Missouri Association of School Nurses, and the MO Eating Disorders Council. The SHP partners with the Missouri Foundation for Health and the Missouri Legal Aid Society to provide training for school health staff on assisting families to understand the Medicaid system. The SHP is sponsoring a one-day seminar to update lead school nurses about unravelling the Public Health Emergency and how schools can best respond. The Director of the Family Support Division at DSS will discuss the Medicaid system, the DESE Food Service Director will discuss family applications for free and reduced meals, and the Missouri School Board Association will provide an update on new laws and policies related to children in schools.

Title V MCH partners with the Missouri Show-Me School-Based Health Alliance (SMSBHA) to advance and advocate for school-based health care programs to improve children's health, educational opportunities, academic achievements, and ultimately, life outcomes. The SMSBHA creates synergy around school-based health through education and training programs, networking, data collection and evaluation, advocacy, and provision of technical assistance for sites.

Title V MCH team members serve as members of the Council for Adolescent and School Health (CASH) to support adolescent and school health and to facilitate collaboration and professional development with others to promote a coordinated family, community, and school approach to achieve healthy adolescent development.

Title V MCH team members participate in the statewide and regional Missouri Department of Transportation (MoDOT) Coalitions for Roadway Safety, partnerships of safety advocates with the common purpose to end traffic fatalities and serious injuries on public roadways. MCH Services Program staff are instrumental in connecting local public health agencies (LPHAs) with the regional coalitions to become involved and gain knowledge and resources to implement their local MCH work plans.

Children and Youth with Special Health Care Needs

The Bureau of Special Health Care Needs (SHCN) partners with several public and private entities in support of children with special health care needs through both formal and informal relationships. Contracts are in place with LPHAs to provide service coordination on a regional basis for the Children and Youth with Special Health Care Needs (CYSHCN) Program. The regional Service Coordinators specialize in resource referrals and are knowledgeable and connected with local businesses, agencies, churches, and philanthropic organizations. SHCN Family Partners are experts in connecting with public and private partners to link families with the appropriate resources. SHCN staff members are involved with various councils, including the Missouri Assistive Technology Advisory Council and the Missouri Developmental Disabilities Council. The Bureau administers the Missouri Brain Injury Advisory Council.

Crosscutting Partnerships

The MCH Director serves on the Advisory Board for ParentLink at the University of Missouri College of Education and Human Development. In addition to contracting with DHSS to manage TEL-LINK, Missouri's toll-free MCH hotline, ParentLink provides parenting resources and support to incarcerated parents, maintains a lending library of parenting materials, and provides the Ages & Stages Questionnaires (ASQ) to help caregivers keep track of their

child's development. DHSS contracted with ParentLink to: 1) implement a statewide MCH Navigator pilot to promote and improve the health and well-being of Missouri's mothers, infants and children by connecting parents, caregivers and families with needed resources to optimize health outcomes; and 2) maintain the ParentLink WarmLine as the access point for caregivers to obtain family strengthening information and support. Through the WarmLine, caregivers can visit with Family Support Specialists, with degrees in human service fields, who can assist them to think through solutions to parenting concerns, obtain community service and other resource information, and access print resources and the Loan Library.

III.E.2.b.v.b. Title V MCH – Title XIX Medicaid Inter-Agency Agreement (IAA)

Service Coordinators and Department of Health and Senior Services (DHSS) Bureau of Special Health Care Needs (BSHCN) Family Partners refer participants and families to MO HealthNet for determination of eligibility and services and assist participants and families in navigating the Medicaid system. The SHCN information system links with the Department of Social Services (DSS) data system to obtain the current Medicaid status of participants. The information system for the Missouri Balanced Incentive Program, also referred to as Missouri Community Options and Resources (MOCOR), refers children and youth with special health care needs (CYSHCN) under the age of 21 to the BSHCN for services. The BSHCN administers the CYSHCN Program; Medicaid referral or verification of active enrollment is a requirement of CYSHCN Program participants. The BSHCN also administers the Healthy Children and Youth (HCY) Program through a cooperative agreement with MO HealthNet. This cooperative agreement also enables the BSHCN to obtain funding support for service coordination activities in the CYSHCN Program. The SHCN HCY Program provides service coordination and authorization for medically necessary services for MO HealthNet state plan fee for service system (not enrolled in the MO HealthNet Managed Care Plans) recipients with special health care needs from birth to age 21. The SHCN HCY Program implements a portion of the Early Periodic Screening Diagnosis Treatment (EPSDT) requirements, including assessing the need for in-home nursing services (such as personal care, private duty nursing and skilled nursing visits) for children and youth with serious and complex medical needs. SHCN Nurse Service Coordinators conduct individual assessments with participants and families in HCY during home visits and link participants and families with services and resources that enable participants to remain safely in their homes. An individual plan of care is created for participants to ensure the unique needs of each person are met. In addition, the BSHCN administers the Medically Fragile Adult Waiver (MFAW) Program, which serves medically complex individuals age 21 and over, who have 'aged out' of the HCY Program. MO HealthNet is the Single State Medicaid Agency; the BSHCN administers the MFAW Program through an interagency agreement with MO HealthNet. An interagency agreement will be developed with MO HealthNet for the DHSS to administer the recently approved Brain Injury Waiver (BIW) Program. The BIW is designed to provide home and community based services to participants ages 21 to 65 with traumatic brain injuries.

Current operations of the BSHCN involve three separate MOUs with the DSS. The DHSS and DSS are exploring the possibility of combining agreements for programs with similar authorities. SHCN staff collaborate with MO HealthNet staff in developing and updating policies and processes related to CYSHCN.

An example of extensive collaboration between the BSHCN and MO HealthNet is related to the implementation of statewide managed care Medicaid. In an effort to minimize negative impact to children receiving in-home services, BSHCN management staff members were included in conversations with MO HealthNet staff, Managed Care Companies, and MO HealthNet providers during the transition to implement managed care statewide. The BSHCN shared processes and forms to promote continuity of statewide operations, regardless of Managed Care/fee for service status. The BSHCN also provided MO HealthNet with a listing of HCY participants prior to the statewide implementation to ensure the participants were appropriately identified and given a choice of receiving services through Managed Care or fee for service. In addition, SHCN staff contacted participants/families receiving services through the HCY Program who were identified as possibly transitioning from fee for service Medicaid to Managed Care to inform them of changes regarding authorization of in-home services and to provide them with information about who to contact with questions regarding their Medicaid status. Ongoing communication between MO HealthNet, Managed Care Companies, provider agencies, and the BSHCN is required post-implementation to ensure effective service provision as individuals change Managed Care Companies and/or fee for service Medicaid, which inadvertently impacts their services. For participants enrolled in the SHCN HCY Program, the BSHCN assists with authorization of in-home services to avoid gaps in services when there are changes in coverage. In addition, the BSHCN provides MO HealthNet with enrollment information on a weekly basis to ensure

participants of the CYSHCN Program are provided an opportunity to choose between Managed Care Medicaid and fee-for-service Medicaid. The BSHCN also collaborated extensively with MO HealthNet through the COVID experience to coordinate services for the HCY and MFAW Programs, including substantial work to allow Missouri flexibility for implementation due to the public health emergency.

A new MOU between the DHSS, the DSS, and the Department of Mental Health sets forth the terms and conditions surrounding utilization and support of the Common Client Area (a centralized repository in which an individual's personal information is input and stored when being assigned a unique identifier). The MOU also establishes a governance structure for the Common Client Area that includes all the agencies that utilize Common Client Area data.

Data Sharing

Additional data sharing agreements between the DHSS and DSS include:

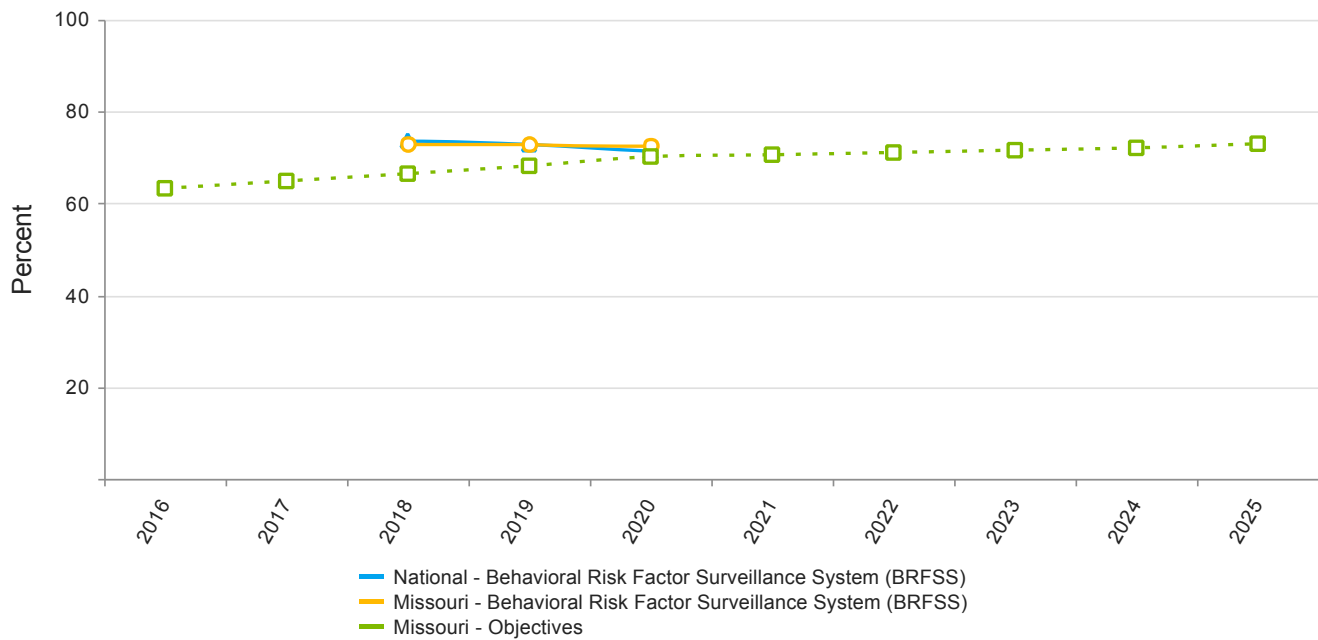
- Vital Records shares birth and death data with DSS to determine eligibility for services.
- Agreement for the DHSS and local public health agencies to perform lead screening and home assessments for children who test positive.
- The DHSS receives Medicaid data to determine eligibility for WIC.

III.E.2.c State Action Plan Narrative by Domain

Women/Maternal Health

National Performance Measures

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year
Indicators and Annual Objectives



Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	2018	2019	2020	2021
Annual Objective				70.1	70.5
Annual Indicator			72.9	72.6	72.5
Numerator			757,602	754,373	755,016
Denominator			1,038,992	1,039,355	1,041,255
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

i Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	64.8	66.4	68.1	70.1	70.5
Annual Indicator	66	72.9	72.6	72.5	72.5
Numerator	699,148	769,769	769,579	755,016	755,016
Denominator	1,059,959	1,055,678	1,060,305	1,041,255	1,041,255
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.0	71.5	72.0	72.9

Evidence-Based or –Informed Strategy Measures**ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).**

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			85.8
Annual Indicator	85.3	83.7	86.7
Numerator	604	1,001	1,204
Denominator	708	1,196	1,388
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	86.2	86.8	87.2	87.9

State Action Plan Table

State Action Plan Table (Missouri) - Women/Maternal Health - Entry 1

Priority Need

Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.

NPM

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Objectives

By 2025, DHSS will develop/promote strategies to increase the percent of women who had an annual preventive medical visit from 72.9% (BRFSS 2018).

By 2025, DHSS will promote strategies to reduce the incidence rate of severe maternal morbidity from 74.0 per 10,000 delivery hospitalizations (SMM rate based on without blood transfusion, PAS 2018).

Strategies

Implement community-based health promotion efforts.

Communicate the value of and collaborate with partners in maternal health initiatives.

Raise awareness of the importance of reproductive life planning.

Educate women on the importance of immunizations.

Promote comprehensive health care for pregnant women and women of childbearing age.

Support activities and facilitate partnerships to create environments that support healthy eating and active living.

Partner with tobacco control programs and community-based partners to assure delivery of effective tobacco cessation services.

Participate in maternal and women's health partnerships by convening public health and advocacy partners for strategic thinking and action, engaging clinicians as partners, and engaging collaboratives to improve maternal health and health care equity.

Address underlying social determinants of health.

Build program and policy evaluation capacity.

ESMs

Status

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Active

NOMs

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

NOM 3 - Maternal mortality rate per 100,000 live births

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

NOM 5 - Percent of preterm births (<37 weeks)

NOM 6 - Percent of early term births (37, 38 weeks)

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

NOM 9.1 - Infant mortality rate per 1,000 live births

NOM 9.2 - Neonatal mortality rate per 1,000 live births

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females

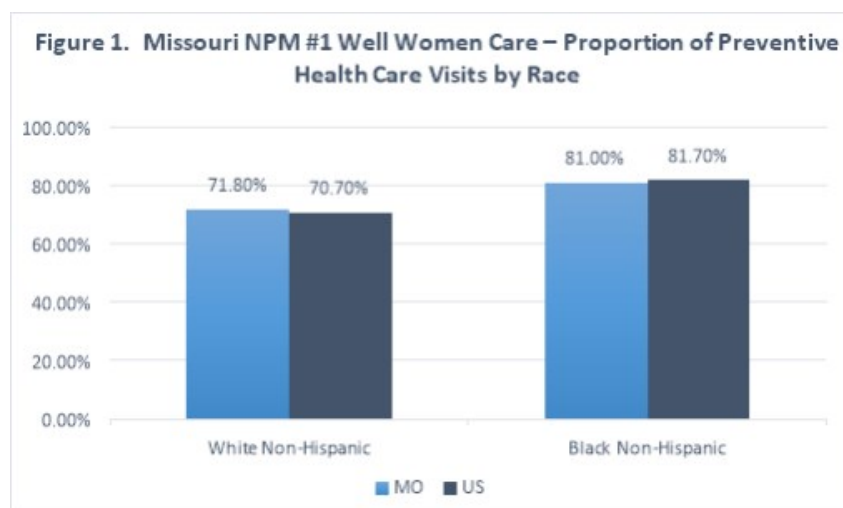
NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth

Women/Maternal Health-Annual Report

NPM #1 Well Women Care – Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.

The health and wellbeing of the mother before, during, and after pregnancy is important not only for the woman but also for the newborn. Women who maintain a healthy lifestyle during the preconception period are less likely to experience adverse pregnancy and obstetric outcomes and are also more likely to experience better postpartum health that extends across their life span.

According to the 2020 Behavioral Risk Factor Surveillance System (BRFSS), 72.5% of Missouri women between 18-44 years reported having a preventive health care visit within the past year. This is higher than the national proportion of 71.3% for 2020. There were racial differences in proportion of preventive health care visit, with Missouri being similar to national levels (Figure 1). A higher percentage of insured women (77.7%) compared to uninsured women (49.5%) received a preventive visit. A lower percentage of those with less than a high school education (56.9%) received a preventive visit in the past year than those with more than a high school education (74.5%). The proportion of Missouri women with more than a high school education that received a preventive medical visit in the past year was also higher than at the national level (72.5%). In Missouri, 67.0% of those with a household income less than \$25,000 had a preventive visit in the past year compared to 79.8% among those with a household income greater than \$75,000. A larger percentage of married women (73.6%) had a preventive visit in the past year than unmarried women (71.5%).



Missouri Vital Statistics (MVS) data for 2020 indicate 73.4% of women began prenatal care in the first trimester, which is slightly lower than the 73.6% observed in 2019. First trimester initiation was also lower in Missouri compared to the national level (77.7%) in 2020. There is a racial gap in first trimester initiation in Missouri, but that gap has narrowed. MVS data for 2020 showed that 76.5% of White Missourians began prenatal care in the first trimester compared to 61.4% of Black Missourians. While first trimester prenatal care initiation increased for Black Missourians (61%) from 2019, it decreased for White Missourians (76.9%) during that same year.

According to 2020 MO PRAMS, 85.1% of Missouri women received a postpartum checkup. This proportion is lower than the 88.6% reported for 2019. Women without health insurance (31.3 %) had the lowest percentage of receiving

a postpartum checkup compared to their counterparts who were privately insured (92.3%) and Medicaid-insured (77.9%). Non-Hispanic Black women (72.9%) had lower rates of receiving a postpartum checkup compared to non-Hispanic White women (87.3 %). Women with less than a high school diploma (70.1%) had lower rates of receiving a postpartum checkup than women with a high school diploma (80.6%), some college (84.2%), and a college degree or higher (92.8%).

The Office on Women's Health (OWH) continued to provide education and resources to promote well woman care, including the distribution of *WOMEN: Take Charge of Your Health* publication and the *My Health Tracking Card* and the continuation of the Women's Health Network listserv. The *WOMEN: Take Charge of Your Health* publication includes information on topics such as preventative health, preconception health, obesity prevention, breastfeeding, postpartum depression, and disease prevention. This resource is also available on the Department of Health and Senior Services (DHSS) website at www.health.mo.gov/womenshealth. The *WOMEN: Take Charge of Your Health* publication is now available in both English and Spanish online and in print. The *My Health Tracking Card* provides a means to track blood pressure, cholesterol, and weight, and is available on the DHSS website at <https://health.mo.gov/living/families/womenshealth/pdf/my-health-tracking-card.pdf>. Resources were provided to the general public, local public health agencies (LPHAs), and others who contact the OWH or visit the website. In FY21, the OWH partnered across the Department to share these resources with medical providers. This partnership helped educate women about the need for health screenings, including breast and cervical exams, blood pressure, cholesterol, and blood sugar monitoring. The Women's Health Network listserv comprises organizations and individuals concerned with women's health. The Network's purpose is to provide timely information about current issues in women's health, such as changes in services for women, changing technology in women's health, available resources, training opportunities, events and funding opportunities. The OWH provides individuals with resources and updates weekly. In the annual survey of these providers, 97% of responses indicated that the listserv was helpful or very helpful in increasing their knowledge of women's health issues.

The Missouri Women's Health Council continued to meet quarterly. The Council is an advisory group comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the DHSS Director and reflect the geographic diversity of Missouri. The Council is charged with informing and advising the DHSS regarding women's health risks, needs, and concerns and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The council consists of women from a variety of professions, including health care providers, researchers, healthcare administrators, social workers, as well as, multiple directors of critical social services foundations serving women throughout Missouri. The Council developed a system for member nominations in FY21 to ensure current members could recommend peers to the DHSS Director and ensure continued diversity of profession, region, and expertise for future years. The Office of Dental Health (ODH) will continue to educate mothers and children about the importance of oral health for their overall health and well-being. This includes the promotion of dental visits during pregnancy. As quantities allow, ODH will supply infant toothbrushes and *Healthy Smiles from the Start* booklets to the St. Louis Safe Kids Coordinator for use during baby safety classes. The classes cover safe sleep habits, car seat safety, breast and bottle-feeding and oral care. The training reaches pregnant moms, new parents and grandparents and is presented in both English and Spanish. For FY21, ODH did not receive requests for the booklets, as the classes were not held due to COVID-19.

The ODH continued to provide education to women about the importance of oral health for the mother's overall health, during pregnancy and throughout her lifespan. This education took place through literature developed by the ODH and the Missouri Dental Association. The materials highlighted the importance of dental visits and were distributed via an ongoing successful collaboration with the Women, Infants, and Children (WIC) Program and the Title V MCH funded Home Visiting Programs. Materials were also distributed via LPHAs, dental offices, and Federally Qualified Health Centers (FQHCs) and at community outreach events. 9,628 materials were distributed to

promote the importance of oral health during pregnancy. To date, three versions of the materials have been translated into Spanish.

Community Health

The MCH Services Program continued to contract with LPHAs to support a leadership role for LPHAs at the community level to promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women:

- Nineteen LPHAs worked to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age as their Priority Health Issue (PHI). LPHAs implemented women's preventative health programs within their health departments, providing women with a low cost annual exam (to include breast and cervical screening) paired with women's health education. The health education covered smoking cessation, self-care tips, and mental wellness resources. As a result, the number of women who received an annual preventative exam increased.
- Eight LPHAs worked to prevent and reduce obesity among women of childbearing age as their PHI. LPHAs used a variety of strategies to encourage and increase physical activity among women of childbearing age.
 - As the COVID-19 pandemic necessitated activities be socially distanced, the Phelps-Maries Health Department held a "virtual" Breastfeeding Walk. Participants were asked to register online, choose a start and end point to walk 3.1 miles, and submit a photo to a private Facebook event page showing they had completed the walk. Those who successfully completed the walk were given a reusable water bottle to increase water intake.
 - The Hickory County Health Department worked with local businesses and distributed a four-month activity calendar, encouraging women of childbearing age to participate in various physical activities each day. 75 calendars were distributed, and nine participants responded to a post-activity survey. The survey showed women of childbearing age reported an increase in physical activity.
 - The Nodaway County Health Department planted a community garden and made fruits and vegetables available to women of childbearing age along with recipe cards so they knew how to prepare a healthy meal with the produce. As a result, women of childbearing age reported an increase in knowledge regarding nutrition.
 - The Pulaski County Health Department facilitated an AquaCize class in the summer months for women of childbearing age. The class was held at the local pool and encouraged women of childbearing age and families to be active.
- Nineteen LPHAs worked to prevent and reduce smoking among women of childbearing age and pregnant women as their PHI. These LPHAs have continued increased efforts to assess smoking in women of childbearing age and offer smoking cessation resources and programs. Outreach efforts have continued to engage community partners and providers to increase collaborative educational efforts and resource sharing, and strengthen referral networks. Many LPHAs used the Smoking Cessation and Reduction in Pregnancy Treatment Program (SCRIPT) and collaborated with WIC programs to identify women of childbearing age that were using tobacco. Using this strategy and program, LPHAs reported an increase in the number of women of childbearing age that were referred and received smoking cessation education as well as an increase in the number of women that quit smoking.
- Three LPHAs worked to decrease the number of women with a recent live birth who experience frequent postpartum depressive symptoms as their PHI. These three LPHAs continued to work collaboratively to increase community awareness of postpartum depression, increase educational opportunities to providers and community members, and increase the awareness, adoption, and implementation of evidence-based postpartum depression screening tools.

- Callaway County Health Department implemented an internal policy to collaborate with the WIC program to screen postpartum women using the Edinburgh screening tool. This resulted in an increased number of women screened and referred for treatment.
- Columbia-Boone County Health Department implemented a peer based support line for postpartum depression, leading to an increase in the number of women who reported feeling supported.

The MCH Services Program also supported LPHA efforts to provide education on the importance of adequate dental care and overall oral health. Activities included collaborating with partners to provide screening and increasing referral and direct provision of preventive dental services in an effort to increase the number of women receiving a preventive dental visit during pregnancy. This collaboration has resulted in an increase in the number of women receiving oral health services during pregnancy as well as an increase in organizations that understand the importance of integrating oral health care. LPHA and/or community partner efforts to implement education programs for pregnant women, families, and providers on the benefits of delivery after 39 weeks gestation, the risks of preterm delivery and cesarean births have also been supported.

The TEL-LINK Program helped improve maternal and child health by providing health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to the underserved population. TEL-LINK provided 2,952 referrals to a wide range of services such as smoking cessation, dental care providers, WIC clinics, food assistance, housing assistance, transportation, health insurance, and many more.

The Newborn Health Program continued to partner with a variety of community health providers to raise awareness/educate the MCH population on MCH resources for women of childbearing age and their families, which include preconception, prenatal, and postpartum care, as well as smoking cessation, postpartum mood disorders, and the importance of taking folic acid. The program accomplishes this through free distribution of the *Pregnancy and Beyond* books and a wide variety of educational materials. All of these resources contain information to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age. The Program tracked the distribution of these materials and obtained feedback from partners on how they use the materials and ways to improve them. The Healthy Births and Babies (HBB) Unit continued to utilize and promote an informal MCH internal work group. Additionally, the HBB Unit maximized outreach opportunities at conference exhibits, webinars, health fairs, and through the Home Visiting Programs by distributing various educational materials.

The Missouri WIC Program promoted the importance of depression screening utilizing the Patient Health Questionnaire-2 (PHQ-2) for prenatal, breastfeeding, and non-breastfeeding woman. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression as a “first step” approach. 22 out of 115 LPHAs implemented the PHQ-2. WIC continued the referral system to the Home Visiting Program, TEL-LINK program, the Missouri Primary Care Association, and other support programs. WIC also continued outreach efforts to enroll prenatal women in the WIC Program in their first trimester.

Home Visiting

The Title V MCH funded Home Visiting Program and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) funded home visiting services, managed under the Department of Elementary and Secondary Education’s (DESE) newly created Office of Childhood (OOC), were offered in 26 counties and served 1,008 families in FY21 through four evidence-based home visiting models:

- Nurse Family Partnership;
- Healthy Families America;

- Parents as Teachers; and
- Early Head Start Home Based Option.

Insurance coverage

The Home Visiting Program continued to share information with all contracted local implementing agencies to help home visitors better understand Affordable Care Act (ACA) Health Insurance Marketplace® changes and uncertainties in order to assist enrolled clients to access insurance for prenatal, postnatal, and well woman care. Home visitors accessed resources through email and postings within the Missouri Home Visiting Gateway resources and through weekly updates on the Home Visiting Program's web-based data collection system platform. The Home Visiting Program recorded the continuity of insurance coverage and provided Marketplace open enrollment information to home visitors throughout the enrollment period. This information was utilized by home visitors to inform their clients of the opportunity and timeline for enrollment. In FY21, 64.8% (508/784) of primary caregivers with medical insurance coverage maintained it continuously for 6 months. Health Insurance Marketplace® open enrollment information was included in every edition of the Weekly Update, provided to all Title V MCH and MIECHV funded home visitors, from November 1, 2020 to December 15, 2020 and again during the Special Enrollment Period initiated due to COVID-19 from April 1, 2021 to May 15, 2021 and through the extension from May 16, 2021 to August 15, 2021. The Home Visiting Program held monthly subrecipient monitoring and support calls with each local implementing agency (LIA) Supervisor with a standing agenda topic of resources agencies need assistance with. When assistance with health coverage for enrolled pregnant and postpartum women is requested, the Home Visiting Program has a contact in the Department of Social Services (DSS) Family Support Division (FSD) User Assistance Team. The Home Visiting Program collected annual performance measure data on the percentage of mothers enrolled in home visiting prenatally or within 30 days after delivery who receive a postpartum visit with a health care provider within 8 weeks of delivery.

Prenatal care

Home Visitors provided information and resources that promote the benefits of pregnancy to the full 40 weeks to all contracted home visitors to share with clients. Resources included DHSS and March of Dimes materials. Title V MCH funded Home Visiting Program Specialists assessed the receipt and use of these resources during monthly subrecipient monitoring and support calls with contracted LIA Supervisors.

Postpartum visit

The Home Visiting Program specifically tracked the number of women enrolled during pregnancy or within 30 days postpartum who received a postpartum follow-up within 8 weeks of delivery. In FY21, 69.1% (132/191) of women received a postpartum follow-up visit.

Smoking Cessation

Home visitors promoted smoking cessation for all primary caregivers who reported smoking at enrollment and at subsequent 6-month time points during enrollment. The Home Visiting Program specifically tracked annual performance measure data on the percentage of primary caregivers who reported smoking and/or use of other tobacco or nicotine products, including e-cigarettes, at enrollment. Caregivers were then provided tobacco cessation referrals for counseling services within three months of enrollment. In addition, home visitors were provided with information and resources on tobacco cessation to share with enrolled participants, such as the DHSS Tobacco Quitline and TEL-LINK. In FY21, this percentage was 65.4% (93/142).

Depression Screening

The Home Visiting Program screened all prenatally enrolled clients within three months of delivery. Primary caregivers not enrolled prenatally were screened within three months of enrollment. Home visitors utilized the Public Health Questionnaire 9 (PHQ-9) depression screening tool at these prescribed time points and anytime they

recognized potential symptoms of depression. Individuals who screened positive were provided support by home visitors through their model curriculums (i.e., Nurse Family Partnership and Early Head Start Home Based Option models) or training received in July 2021 (i.e., Parents as Teachers and Healthy Families America models) for the Mothers & Babies Mental Health Intervention developed by The Center for Community Health at Illinois Northwestern University, Institute for Public Health and Medicine. This intervention promoted healthy mood management by teaching pregnant women and new moms how to effectively respond to stress. When PHQ9 scores indicated, referrals were made to the appropriate services. The FY21 data showed that 83.6% (285/341) of enrolled clients meeting these criteria were screened. 31 individuals screened positive and 10 had completed referrals for appropriate services. Follow-ups were made to ensure completion of referrals by making a connection between client and referral source.

Oral Health

The Home Visiting Program provided ordering information for oral health resources from the Office of Dental Health (ODH) and the Missouri Primary Care Association (MPCA) via email to all MCH and MIECHV funded home visitors and supervisors, as well as links to materials, webinars, and other resources that highlight the importance of preventive annual dental care ahead of the virtual Title V/MCH and MIECHV specific home visiting summit held on March 10, 2021.

Environmental Health

Many persons are not aware that lead exposure can be a problem for women of childbearing age, a developing fetus and/or a nursing infant. The most serious effects of high levels of lead exposure during pregnancy are miscarriage and stillbirth. Other pregnancy problems such as gestational hypertension, low birth weight and premature delivery can also occur. Prenatal lead exposure impairs children's neurodevelopment, placing them at increased risk for developmental delay, reduced IQ, hearing impairments, and learning and behavioral problems.

DHSS lead poisoning prevention staff continued the following activities to prevent or decrease blood lead poisoning in pregnant women and their babies:

- Provided community lead education via various outreach events such as health fairs, home shows, and public information sessions.
- Participated in updating outreach materials such as the "Pregnancy and Beyond" booklet and other pamphlets and brochures which are distributed to expectant and new parents.
- Made contact with pregnant women and their health care providers when they were known to have elevated blood lead levels (EBL) of 5 mcg/dL or higher (tracked by the ABLES staff), provided educational materials, and offered lead risk assessments.
- Provided lead education and resource materials to health care providers, LPHA and health plan lead case managers, as well as WIC program staff regarding the need to discuss lead poisoning prevention and lead testing with clients. This included providing LeadCare Analyzers and lead test kits to LPHAs that did not have the capacity to provide accurate lead screenings—allowing them to offer this service on a regular and ongoing basis.

The Prenatal Substance Use Prevention Program educated pregnant women on the importance of prenatal substance use prevention to promote healthy pregnancy and birth. The program utilized statewide community placement sites, which house substance exposed infant manikins to demonstrate the effects of drugs and alcohol exposure during pregnancy. Despite the challenges of COVID-19, the community placement sites were able to demonstrate the substance exposed manikins 137 times, educating 2,635 individuals. Educators reported that students were full of empathy for the infant manikins. Educators also noted that a women's recovery group was in

tears as the manikins hit very close to home. Participants reported that it's different knowing what could happen and then seeing the side effects of drinking while pregnant. They had no idea alcohol could be so harmful to babies. Participants also demonstrated concern about the guilt a parent might feel if they were struggling with substance use.

In addition, the Prenatal Substance Use Prevention Program created awareness campaigns that were displayed to 1,822,430 individuals to promote healthy pregnancy and to educate women of childbearing age on the importance of avoiding all substance use before, during, and after pregnancy.

The Safe Cribs for Missouri Program continued to educate each crib recipient on smoking cessation and the consequences of smoking during pregnancy. Missouri Tobacco Quitline tip cards and MO HealthNet resources were utilized. The Safe Cribs Program Specialist continued to follow-up with contracting agencies to ensure they were providing health education. The Program Specialist was also available to provide resources as needed.

Maternal Mortality

The OWH continued to abstract and review all pregnancy-associated mortalities in Missouri. This was done to ensure that information from all maternal deaths occurring within one year of pregnancy termination was captured. These reviews aided in the identification of strategies to prevent maternal mortalities. DHSS reported findings from the Pregnancy-Associated Mortality Review (PAMR) by publishing the *Missouri Pregnancy-Associated Mortality Review: 2018 Annual Report*. The report was disseminated to a broad audience and made available on the PAMR web site at <https://health.mo.gov/data/pamr/index.php>. The Maternal/Infant Coordinator completed 15 presentations on PAMR data to various stakeholder groups.

The Maternal/Infant Mortality Coordinator and the MCH Director participated in the planning and sponsorship of the 2021 Virtual Convening for Maternal and Infant Health in Missouri. This event convened maternal and infant health providers, stakeholders, and invested community partners from all across the state to learn, share progress, and walk away with actionable insights. More than 300 people registered with approximately 170-180 participating that day. This event was a partnership between the Missouri Foundation for Health (MFFH), Missouri Hospital Association, and the DHSS and was provided free of charge to participants as a result of this partnership.

The DHSS was selected through a competitive grant process for a 5-year grant awarded through the Centers for Disease Control and Prevention's (CDC) Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) Program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees (MMRC) to identify, review and characterize maternal deaths and identify prevention opportunities. The Maternal/Infant Mortality Coordinator worked closely with the PAMR Board and the Title V MCH Block Grant Program to implement the strategies in this grant. The OWH improved internal processes to expedite maternal mortality case identification, abstraction and review by working with the Bureau of Vital Records to use provisional death files. Furthermore, maternal mortality cases were grouped by date of death for abstraction and review. For example, deaths that occur at the beginning of the year are abstracted first if at all possible and brought to the PAMR Board. These process improvements increased timely case identification from 45% (baseline) to 87%. In addition, the Patient Abstract System (PAS) linkage that was developed during year two of the grant to identify additional hospitalizations/emergency room visits has proved to be extremely beneficial for case abstraction. For example, the PAS linkages provided identification of medical care access that otherwise would have been missed. Additionally, through the ERASE MM grant, the OWH continued a contract with the Missouri Hospital Association (MHA) to implement the Severe Hypertension in Pregnancy (SHP) patient safety bundle in Missouri birthing facilities, clinics and critical access hospitals. Ultimately, 31 birthing centers, eight emergency rooms/critical care access hospitals and seven provider clinics participated. Multiple coaching calls, virtual office hours for collaborative team support, peer-to-peer meetings with physician faculty, and data support were offered to participants. Overall, there

was a combined improvement (17.18%) in the rate of treatment of medication measure which ensures women who present with severe high blood pressure are treated in a timely manner. One reoccurring theme noted in the maternal mortality case reviews is poor follow up for patients diagnosed with hypertension in pregnancy. Participating entities in the collaborative reported that 76% of participants in the birthing unit track reported scheduling follow-up appointments for patients with a diagnosis of hypertension, preeclampsia or eclampsia within 7-14 days of discharge. Within the provider clinic track, 85% of participants reported patients adhered to the scheduled follow-up. The number of hospital births statewide covered by implementation of the AIM SHP bundle was 40,250, which equates to 59% of the total births in Missouri. The collaborative moved into the sustainability phase continuing to report data on a bi-monthly basis. The SHP collaborative resulted in these additional improvements: bundle completion increased from an average of 59% to 91%, structure measure completion increased from an average of 81% to 90% and the team process improvement measure completion increased from an average of 81% to 93%. One of the more notable changes included provider education on severe hypertension including the unit-based protocol which increased from 49% (1st quarter) to 92% (4th quarter). Lastly, to ensure that efforts and improvements did not cease at the close of the collaborative, MHA created a sustainability plan for the organizations. The sustainability plan was implemented allowing organizations to continue to monitor their efforts. Missouri shared the sustainability plan with the AIM National Team as this is the first of such a plan to have been developed. Prior to the end of the SHP collaborative, planning work began on the implementation of the “Obstetric Care for Women with Opioid Use Disorder” bundle. Maternal overdoses were identified as a leading cause of death for PAMR in the report released in 2021.

The DHSS and the Missouri Hospital Association continued to work together on the Maternal and Child Learning Action Network (MC-LAN) and the Alliance for Innovation on Maternal Health (AIM). The Maternal/Infant Mortality Coordinator and MCH Director participated in the Missouri Maternal-Child Learning and Action Network (MC LAN) by providing guidance, data, knowledge sharing and peer support in developing strategic quality initiatives based on the Triple AIM principles of improving and evaluating perinatal quality and population-based programs. The MC-LAN provides guidance, knowledge sharing and peer support in developing strategic quality initiatives based on the Triple Aim principles. The committee partners with the communities they serve to achieve better communication, and educate and impact the public on quality and safety initiatives of the health care community. AIM is a national data-driven maternal safety and quality improvement initiative, and Missouri was designated as an AIM state in 2018. As part of the current Obstetric Care for Women with Opioid Use Disorder AIM Bundle, the Missouri Neonatal Abstinence Syndrome Collaborative was formed to focus on developing improvements in care related to the care of substance-exposed newborns, including keeping the mother-infant dyad intact; incorporating the functional assessment model Eat, Sleep, Console into practice; and establishing Safe Plans of Care of the mother and the infant.

One example of a population-based program implemented during the time of the COVID-19 pandemic when most in-person office visits were ceased included *The Cuff Kit*™ Project. As a result of meetings between partners discussing the effect of the pandemic on the health and safety of pregnant women, several partners came together to apply for and fund *The Cuff Kit* Project. *The Cuff Kit* Project distributed comprehensive blood pressure cuff kits to pregnant women at high risk for or diagnosed with blood pressure-related issues. The cuff kits were also distributed to other vulnerable populations. Organizations participating in the Missouri AIM SHP Collaborative were given first priority to receive the kits. Additional opportunities were given primarily to FQHCs serving maternal patients in identified high-need regions of Missouri. In coordination with the Preeclampsia Foundation, blood pressure cuff kits were distributed to organizations able to accomplish the following:

- Utilize telehealth technologies to communicate with participating patients;
- Provide patients with the entire cuff kit package;
- Prioritize distribution to those at highest risk, especially vulnerable women with a lower ability to procure their

own blood pressure cuff:

- At-risk and vulnerable women include those with: chronic hypertension, history of preeclampsia and/or eclampsia, obesity, advanced maternal age, autoimmune disorders and other medical diagnoses, as well as those with population-level risk factors, such as race (Black, Native American), and/or live in a rural location;
- Conduct a brief survey to assess initiative impact and encourage patient feedback submission through an enclosed postage-paid postcard; and
- Provide outcome data and patient success stories.

Altogether 33 organizations participated in *The Cuff Kit* Project distributing kits to 2,935 women. This program was so well received that the Missouri Foundation for Health provided matching funds to enable additional kits to be distributed beyond the initial funding for 1,500 kits. Participants who received a cuff kit reported that, in a time where they felt extremely isolated, having the cuff kit at home enabled them to monitor their health safely and identify when they needed to seek medical attention.

Other Title V Program Activities Related to the Women/Maternal Health Domain

The OWH supports several initiatives to assist women of childbearing age. First, the office supports the Uninsured Women's Health Services Program. With the DSS, the OWH reimburses medical providers for women's health services. These include: approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; family planning, counseling, education on various methods of birth control; and drugs, supplies, or devices related to the women's health services described above, when they are prescribed by a physician or advanced practice nurse. Second, the OWH maintains a public listing of pregnancy assistance information and ultrasound providers. The OWH sends a survey annually in order to develop a listing of private and public agencies available in the state to help pregnant women. This listing of assistance providers and ultrasound providers is indexed geographically and available online. Third, the OWH represents or supports the Department in several statewide task forces and commissions, including the Missouri Rights of Victims of Sexual Assault Task Force, the Combatting Human Trafficking and Domestic Violence Commission, and the Missouri Women's Health Council. Finally, the OWH supports the statewide Sexual Assault Nurse Examiner Telehealth Network. This network is in the beginning stages and will expand access to forensic exams across the state.

The DHSS participated in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community. The Title V MCH Block Grant program formed a core team, including: the MCH Director as the team lead, behavioral health representation from the DSS, MO HealthNet Division and the Department of Mental Health, and members from the University of Missouri Kansas City Institute for Human Development and the Dallas County Health Department. The PRISM Learning Community provided technical assistance and capacity building to support and advance policy implementation within states and territories to equitably address substance misuse and addiction and mental health disorders in women, children, and families within the context of the COVID-19 pandemic. The core team created a state action plan to achieve the following goals:

- Goal #1: Leverage Missouri's existing maternal-fetal-infant/neonatal abstinence syndrome (MFI/NAS) workgroups to organize a multisector action network, focused on a life course framework, to coordinate and collaborate on maternal mental health and substance use prevention and treatment efforts.
- Goal #2: Conduct a landscape analysis of existing state approaches for addressing maternal mental health and substance use disorders, to inform Missouri's future policy efforts.
- Goal #3: Create a policy proposal that advances maternal mental health and substance use prevention and

treatment, using a sustainable funding approach.

AMCHP worked with the Georgia Health Policy Center at the Andrew Young School of Policy Studies to conduct a landscape scan of state policy options for perinatal women with substance use disorders for Missouri's PRISM project. The DHSS contracted with the UMKC-Institute for Human Development to convene a Maternal Health Multisector Action Network to leverage Missouri's existing maternal-fetal-infant/neonatal abstinence syndrome (MFI/NAS) work groups and coordinate and collaborate on maternal mental health and substance use prevention and treatment efforts.

As the state's chief MCH strategist, the MCH Director worked to broaden the scope of Title V partnership beyond the DHSS and other state agencies. As a convener of multidisciplinary, cross-sector collaborations and facilitator of meaningful and diverse partnerships, Title V brought MCH partners and programs together across programmatic silos and organizational boundaries to promote the health of the MCH population and address social determinants of health and health inequities. For example, the MCH Director facilitated a statewide Healthy Start Collaborative with the two Healthy Start grantees (Nurture KC, and Missouri Bootheel Regional Consortium) and their partners to facilitate virtual sharing of information and resources, shared learning and identification of opportunities for alignment and collective impact. The MCH Director was actively engaged in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to PAMR, the MC-LAN, the Women's Health Council, the DSS-Maternal Fetal Infant Workgroup and Substance Use Disorder and Social Determinants of Health sub-workgroups, the Uplift Connection, the MFFH Maternal Mortality Stakeholder group, and the Kansas City Perinatal Recovery Collaborative.

Women/Maternal Health - Application Year

NPM #1 Well Women Care – Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.

The Office on Women's Health (OWH) will continue to provide education and resources to promote well woman care, including the distribution of *WOMEN: Take Charge of Your Health* publication and the *My Health Tracking Card* and the continuation of the Women's Health Network listserv. The *WOMEN: Take Charge of Your Health* publication includes information on topics such as preventative health, preconception health, obesity prevention, breastfeeding, postpartum depression, and disease prevention. It will be updated as needed to include new evidence-based information and recommendations from experts and leaders in women's health. This resource is also available on the Department of Health and Senior Services (DHSS) website at www.health.mo.gov/womenshealth. The *WOMEN: Take Charge of Your Health* publication is now available in both English and Spanish online and in print. The *My Health Tracking Card* provides a means to track blood pressure, cholesterol, and weight, and is available on the DHSS website at <https://health.mo.gov/living/families/womenshealth/pdf/my-health-tracking-card.pdf>. Resources are provided to the general public, local public health agencies (LPHAs), and others who contact the OWH or visit the website. The Women's Health Network listserv comprises organizations and individuals concerned with women's health. The Network's purpose is to provide timely information about current issues in women's health, such as changes to services for women, changing technology in women's health, available resources, training opportunities, events and funding opportunities.

The Missouri Women's Health Council will continue to meet quarterly. The Council is an advisory group comprised of thought leaders with expertise in women's health and the broad range of factors that affect health outcomes and wellbeing. Council members are appointed by the DHSS Director and reflect the geographic diversity of Missouri. The Council is charged with informing and advising the DHSS regarding women's health risks, needs, and concerns and recommending potential strategies, programs, and legislative changes to improve the health and well-being of all women in Missouri. The Council consists of women from a variety of professions, including health care providers, researchers, healthcare administrators, social workers, as well as, multiple directors of critical social services foundations serving women throughout Missouri.

The Office of Dental Health (ODH) will continue to educate mothers and children about the importance of oral health for their overall health and well-being during pregnancy and throughout the lifespan, including the promotion of dental visits during pregnancy. This education takes place through literature developed by the ODH and the Missouri Dental Association. These materials are distributed to women via an ongoing successful collaboration with the Women, Infants, and Children (WIC) Program and the Title V MCH funded Home Visiting Program. Materials are also distributed via LPHAs, dental offices, and at community outreach events. The importance of dental visits among pregnant women is reinforced in literature distributed by the ODH via its collaboration with WIC, the Home Visiting Program, and Federally Qualified Health Centers (FQHC).

The ODH is also piloting a program to provide funding to two-three LPHAs through their WIC office to provide oral health education, oral health supplies, fluoride varnish and a warm hand off to a dental provider for dental care. The LPHA encourages the mother to keep the appointment by emphasizing the importance of oral care during pregnancy. The LPHA then tracks the mother's visit to the dentist to see how successful they were in their education.

Community Health

The MCH Services Program will continue to contract with LPHAs to support a leadership role for LPHAs at the community level to promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for

low income, at-risk pregnant women:

- Twenty LPHAs have selected to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age as their Priority Health Issue (PHI).
- One LPHA has selected to prevent and reduce obesity among women of childbearing age as their PHI.
- Four LPHAs have selected to prevent and reduce smoking among women of childbearing age and pregnant women as their PHI. These LPHAs will continue to increase efforts to assess smoking in women of childbearing age and offer smoking cessation resources and programs. Outreach efforts will continue to engage community partners and providers to increase collaborative educational efforts and resource sharing, and strengthen referral networks.
 - The Ozark County Health Department is developing Quit Kits that include tobacco cessation education and resources that are provided to local medical providers to use with women of childbearing age that have been screened and identified as using tobacco. They are also being provided to women of childbearing age that present to the health department for WIC and have been screened and identified as using tobacco.
 - The Chariton County Health Department is collaborating with the WIC office to screen and identify women of childbearing age that are smoking. Those identified are referred to a nurse who administers the Smoking Cessation and Reduction in Pregnancy Treatment (SCRIPT) Program. This is coordinated with the WIC visit to minimize the number of visits the woman has to make to the office.
 - The Perry County Health Department is working to expand the Baby and Me Tobacco Free program into their WIC program, which screens women of childbearing age for smoking status. This will allow the health department to provide on-site smoking cessation resources for women of childbearing age.
- Two LPHAs have selected to decrease the number of women with a recent live birth who experience frequent postpartum depressive symptoms as their PHI and one LPHA has selected to improve mental health care services for women of childbearing age. These three LPHAs will continue to work collaboratively to increase community awareness of postpartum depression, increase educational opportunities to providers and community members, and increase the awareness, adoption, and implementation of evidence-based postpartum depression screening tools.
 - The Callaway County Health Department is collaborating with the WIC program to screen postpartum participants ~~with consent~~ using the Edinburg screening tool and providing referral and resources to mental health services as needed. The screening tool is available in both English and Spanish and can be found at https://med.stanford.edu/content/dam/sm/ppc/documents/DBP/EDPS_text_added.pdf. They are also using the Missouri Birth Report records to identify women who have had a recent birth and mailing mental health resources to the address listed on the birth report.
 - The Springfield-Greene County has required all staff be trained in the Advancing Health Equity training series and have incorporated this training into NEST Partnership. NEST stands for NUTURE, EMPOWER, SUPPORT, and TEACH. NEST Partnership provides nurse case management for at-risk prenatal and postpartum women or families with young children. Services are delivered in the home during scheduled visits for nurse assessment, intervention, education and collaboration with health care providers.
- Ten LPHAs have selected to ensure women of childbearing age receive an annual preventative well visit. Some will be changing organizational practices to include well-woman care as part of the services offered at their health departments while others will be collaborating with local FQHCs to screen and refer for services.
 - McDonald County Health Department is working to increase the number of women who have an annual preventative visit and created Self-Care Kits to use as an incentive for women of childbearing age that complete this visit at the health department. These kits include items to promote physical and mental health for the woman such as a water bottle to increase water intake, a pedometer to increase physical

- activity by encouraging walking, and a cookbook to increase knowledge on preparing a healthy meal.
- The Atchison County Health Department is working to increase services integrated into the annual women's preventative health services program to include mental health screening and referral and smoking cessation education and resources.
- Two LPHAs have selected to reduce racial disparities and ensure Black women of childbearing age receive preconception, prenatal, and postpartum health care services. These LPHAs plan to work closely with their internal and external partners, including but not limited to local hospital labor and delivery units and universities within their medical training programs.
 - The St. Louis County Department of Public Health is working to develop and adopt a birth justice policy to include screening pregnant women to determine the need for doula and home visiting nursing care with the intent to build trust in the healthcare system resulting in improved birth outcomes.
 - The City of St. Louis Department of Health is working to develop inclusive, culturally congruent care models and policies specific to implicit bias that OBGYN clinical staff, including physicians and nurses, will implement into practice as a required annual training.

The MCH Services Program will also support LPHA efforts to provide education on the importance of adequate dental care and overall oral health. LPHAs will collaborate with partners to provide screening, referral and direct provision of preventive dental services, and increase the number of women receiving a preventive dental visit during pregnancy. LPHA and/or community partner efforts to implement education programs for pregnant women, families, and providers on the benefits of delivery after 39 weeks gestation, the risks of preterm delivery, and the risks associated with a cesarean birth will also be supported.

The TEL-LINK program will help improve MCH by providing health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to the underserved population. TEL-LINK is able to provide referrals to a wide range of services, such as smoking cessation, dental care providers, WIC clinics, mental health treatment centers, health insurance providers, and many more.

The Newborn Health Program will continue to partner with a variety of community health providers to raise awareness/educate the MCH population on MCH resources for women of childbearing age and their families, including preconception, prenatal, and postpartum care, smoking cessation, postpartum mood disorders, and the importance of taking folic acid. The program will accomplish this through the free distribution of the *Pregnancy and Beyond* books and a wide variety of educational materials. All of these resources contain information to improve pre-conception, prenatal, and postpartum health care services for women of childbearing age. The Program will track the distribution of these materials and obtain feedback from partners on how they use the materials and ways to improve them. The Healthy Births and Babies (HBB) Unit will continue to utilize and promote an informal MCH internal work group and maximize outreach opportunities at conference exhibits, webinars, virtual baby showers, health fairs, and through the Home Visiting Programs by distributing various educational materials.

The Missouri Women, Infants, and Children (WIC) Program will promote the importance of depression screening utilizing the Patient Health Questionnaire-2 (PHQ-2) for prenatal, breastfeeding, and non-breastfeeding woman. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression in a "first step" approach. WIC will continue the referral system to the Home Visiting Program, TEL-LINK program, the Missouri Primary Care Association, or other support programs. WIC will also continue outreach efforts to enroll prenatal women in the WIC Program in their first trimester.

Home Visiting

The Title V MCH funded Home Visiting Program will continue to share information with all contracted local implementing agencies to help home visitors better understand the Affordable Care Act (ACA) marketplace changes and uncertainties. Home visiting staff will assist enrolled clients to access insurance for prenatal, postnatal, and well woman care through emails and postings within the Missouri Home Visiting Gateway resources and the Weekly Updates that are shared on the Home Visiting Program's web-based data collection system platform. Through a standard agenda topic on the monthly subrecipient monitoring and support calls with each contracted local implementing agency supervisor, Home Visiting Program Specialists will continue to address needs for updated resources for accessing a regular and ongoing source of healthcare, including current guidelines for accessing and maintaining insurance coverage. The Home Visiting Program will also collect annual performance measure data on the percentage of mothers enrolled in home visiting prenatally or within 30 days after delivery who receive a postpartum visit with a health care provider within 8 weeks of delivery.

Additional Title V MCH funded Home Visiting Program Services include:

- Promoting smoking cessation for to all primary caregivers who report smoking at enrollment and/or the subsequent 6-month visit. Annual performance measure data will be collected on the percentage of primary caregivers who report smoking, tobacco use or other forms of nicotine delivery, including e-cigarettes, at enrollment and are referred to tobacco cessation counseling or services within three months. In addition, home visitors will be provided with tobacco cessation information and resources, such as the DHSS Tobacco Quitline and TEL-LINK, to share with enrolled participants;
- Providing information and resources with all enrolled pregnant women promoting the benefits of continuing healthy pregnancies to the full 40 weeks. These resources will include DHSS and March of Dimes educational materials. Title V MCH funded Home Visiting Program Specialists will assess the distribution and use of these resources during monthly subrecipient monitoring calls with contracted local implementing agencies;
- Screening all clients enrolled prenatally for symptoms of depression within three months of delivery. Primary caregivers not enrolled prenatally will be screened within the first three months of enrollment. Home visitors will utilize the Public Health Questionnaire 9 (PHQ-9) depression screening tool during these prescribed timeframes and anytime home visitors recognize potential symptoms of depression, referring individuals who screen positive to appropriate services. Annual performance measure data will be collected for depression screening as described above. Additionally, annual performance measure data will be collected on the percentage of completed referrals to services after a positive depression screening. Current resources on mental health are shared with contracting local implementing agencies through Weekly Updates.
- Providing contracted home visitors with ordering information for oral health resources from the ODH and the Missouri Primary Care Association to share with enrolled primary caregivers promoting the importance of receiving preventive dental care during pregnancy and at all stages of life for both primary caregivers and their children.

Environmental Health

Many persons are not aware that lead exposure can be a problem for women of childbearing age as well as the developing fetus and/or nursing infant. The most serious effects of high levels of lead during pregnancy are miscarriage and stillbirth. Other pregnancy problems such as gestational hypertension, low birth weight and premature delivery can also occur. Prenatal lead exposure impairs children's neurodevelopment, placing them at increased risk for developmental delay, reduced IQ, hearing impairments, and learning and behavioral problems.

DHSS lead poisoning prevention staff will continue to perform the following activities to prevent or decrease blood lead poisoning in pregnant women and their babies:

- Provide community lead education via various outreach events such as health fairs;
- Participate in updating outreach materials such as the “Pregnancy and Beyond” booklet and other pamphlets and brochures which are distributed to expectant and new parents;
- Make contact with women and their health care providers when pregnant women have elevated blood lead levels (EBL) of 5 mcg/dL or higher (tracked by the Adult Blood Lead Epidemiology and Surveillance staff); and
- Provide lead education and resource materials to health care providers, LPHA and health plan lead case managers, as well as WIC program staff regarding the need to discuss lead poisoning prevention and lead testing with clients. This will include providing LeadCare Analyzers and lead test kits, as available, to LPHAs that do not have the capacity to provide accurate lead screenings, allowing them to offer this service on a regular and ongoing basis.

The Prenatal Substance Use Prevention Program will promote the importance of prenatal substance use prevention to promote healthy pregnancy and childbirth. The program utilizes statewide community placement sites, which house substance exposed infant manikins to demonstrate the effects of drugs and alcohol during pregnancy. In addition, awareness campaigns will promote healthy pregnancy and abstaining from all substances before, during, and after pregnancy.

The Safe Cribs for Missouri Program will continue to educate each crib recipient on smoking cessation and the consequences of smoking during pregnancy. Missouri Tobacco Quitline tip cards and MO HealthNet resources will be utilized.

Maternal Mortality

The DHSS OWH will continue to abstract and review all pregnancy-associated mortalities in Missouri. This will be done to ensure that information from all maternal deaths occurring within one year of pregnancy is captured. These reviews will aid in the identification of strategies to prevent maternal mortalities. The DHSS will report findings from the Pregnancy-Associated Mortality Review (PAMR) and collaborate with partners and other key stakeholders to implement PAMR recommendations.

The DHSS was selected through a competitive grant process for a 5-year grant awarded through the Centers for Disease Control and Prevention’s (CDC) Enhancing Reviews and Surveillance to Eliminate Maternal Mortality (ERASE MM) program. This funding directly supports agencies and organizations that coordinate and manage Maternal Mortality Review Committees (MMRC) to identify, review and characterize maternal deaths and identify prevention opportunities. The OWH continues to improve internal processes to expedite maternal mortality case identification, abstraction and review by working with the Bureau of Vital Records to use provisional death files. Furthermore, maternal mortality cases are grouped by date of death for abstraction and review. For example, deaths that occur at the beginning of the year are abstracted first if possible and brought to the PAMR Board. These process improvements will continue to be refined during year three of the grant. In addition, a Patient Abstract System (PAS) linkage was developed during year two of the grant to identify additional hospitalizations/emergency room visits to aid in case abstraction. The PAS linkage will be further refined during year three of the grant. Through the ERASE MM grant, the OWH contracts with the Missouri Hospital Association (MHA) to implement patient safety bundles in Missouri birthing facilities, clinics and critical access hospitals. This work will continue and includes plans to implement “Obstetric Care for Women with Opioid Use Disorder” bundle. Maternal overdoses were identified as a leading cause of death for PAMR in a report published in June 2021 titled, “Missouri Pregnancy-Associated Mortality Review: 2018 Annual Report”. The OWH Maternal/Infant Mortality Coordinator will work closely with the PAMR Board

and Title V MCH Program to implement the initiatives in this grant.

Soon after launching the Missouri Maternal-Child Learning and Action Network (MC-LAN) in 2018, the DHSS and MHA partnered to join the American College of Obstetricians and Gynecologists (ACOG), as funded by the Health Resources and Services Administration, Alliance for Innovation on Maternal Health - AIM. Through this effort, MHA is taking the lead on implementation of maternal safety bundles in Missouri birthing facilities. As the first initiative, Missouri began implementing the AIM “Severe Hypertension in Pregnancy” patient safety bundle. The OWH will continue collaborating with MHA and other key stakeholders through the MC LAN to provide guidance, knowledge-sharing and peer support in developing strategic quality initiatives based on the Triple Aim principles of improving and evaluating perinatal quality and population-based programs. The MC LAN provides strategic guidance and focuses on high-value opportunities to improve clinical, operational and outcome performance, and to develop collaborative partnerships to achieve these aims. In addition, the committee partners with the communities they serve to achieve better communication, and educate the public on quality and safety initiatives of the health care community. This committee meets three times a year with additional virtual platform meetings as needed. MO birthing facilities enrolled in the AIM will be required to report data metrics into the AIM data portal. The DHSS and MHA will assist birthing facilities with data submission to minimize burden on the facilities, and the DHSS will work with MHA to leverage key stakeholders to assist with the process of implementing AIM bundles in interested facilities.

Other Title V Program Activities Related to the Women/Maternal Health Domain

The OWH supports several initiatives to assist women of childbearing age. The Office supports the Uninsured Women’s Health Services Program. With the Missouri Department of Social Services, the OWH reimburses medical providers for women’s health services. These include: approved methods of contraception; sexually transmitted disease testing and treatment, including pap tests and pelvic exams; family planning, counseling, education on various methods of birth control; and drugs, supplies or devices related to the women’s health services described above, when they are prescribed by a physician or advanced practice nurse. The OWH maintains a public listing of pregnancy assistance information and ultrasound providers. The OWH sends a survey annually in order to develop a listing of private and public agencies in the state to help pregnant women. This listing of assistance providers and ultrasound providers is indexed geographically and available online. Common services provided include food, clothing, supplies related to pregnancy, parenting skills and educational programs, and adoption assistance. The OWH also represents the Department on several statewide task forces and commissions, including the Missouri Rights of Victims of Sexual Assault Task Force and the Combatting Human Trafficking and Domestic Violence Commission. Finally, the OWH supports the statewide Sexual Assault Nurse Examiner Telehealth Network. This network is in the beginning stages and will expand access to forensic exams across the state.

Through participation in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community, the DHSS leveraged Missouri’s existing maternal-fetal-infant/neonatal abstinence syndrome (MFI/NAS) workgroups and contracted with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to organize, convene and facilitate a statewide Maternal Multisector Action Network (the Network). Focused on a life course framework, the Network promotes a coordinated, multidisciplinary system of care for women of childbearing age and pregnant and parenting mothers to assure health equity, racial/social justice, and a comprehensive continuum of care, including prevention and treatment efforts, for women/mothers with mental health and substance use disorders (SUD). The Network will use a landscape scan of State Policy Options for Perinatal Women with Substance Use Disorders provided by AMCHP to inform its priorities, goals, strategies, and future policy initiatives and will address risk and protective factors that influence health disparities within families and communities through the Life Course Perspective. A diverse, multisector and representative group of MCH, public

health, mental health, behavioral health, SUD treatment, social services, and community partners and stakeholders, including LPHAs, will be invited to participate in Network efforts. To incorporate the lived experiences of mothers of young children affected by substance use and mental health challenges, the Network will promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities. The UMKC-IHD will conduct focus groups or “mapping sessions” to better understand the facilitators and barriers to accessing high quality and equitable services for mothers affected by substance use and mental health disorders. The UMKC-IHD will recruit two groups of individuals for focus groups: Mothers of young children affected by substance use throughout the state of Missouri and service providers or individuals who work at organizations/agencies that provide support/services to mothers of young children affected by substance use and mental health disorders. Understanding the lived experiences of mothers with substance use and mental health disorders and front-line clinical and social service professionals who work with women with substance use and mental health disorders before, during and/or after pregnancy will help guide the development of future services and support systems available to address maternal substance use and mental health, resulting in improved health outcomes for mothers and their children. The Multisector Action Network has identified the following five priority areas associated with maternal substance use and mental health:

1. Social Determinants of Health/Stigma/Justice/Equity;
2. Wraparound Services/Team Birth Approach;
3. Medicaid Expansion;
4. Child and Family Support Services; and
5. Criminal Justice Issues.

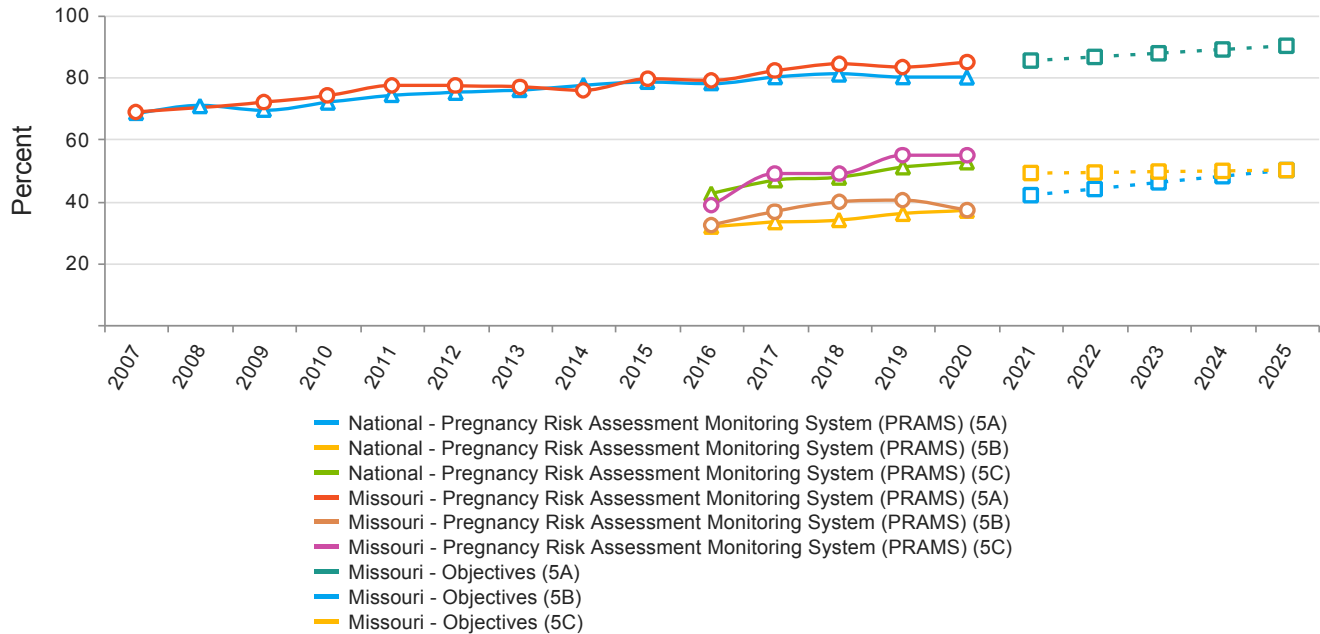
Work groups are being formed around the five priority areas, and the landscape scan will help identify areas of strength, opportunities, gaps in services, and policy options.

As the state’s chief maternal child health strategist, the MCH Director works to broaden the scope of Title V MCH partnership beyond the DHSS and other state agencies. As a convener of multidisciplinary, cross-sector collaborations and facilitator of meaningful and diverse partnerships, Title V brings MCH partners and programs together across programmatic silos and organizational boundaries to promote the health of the MCH population and address social determinants of health and health inequities. For example, the MCH Director facilitates a statewide Healthy Start Collaborative with the two Healthy Start grantees (Nurture KC, and Missouri Bootheel Regional Consortium) and their partners to facilitate sharing of information and resources, shared learning and identification of opportunities for alignment and collective impact. The MCH Director will continue to be actively engaged in statewide collaborative efforts to promote the health of women of childbearing age, including but not limited to PAMR, the MC-LAN, the Women's Health Council, the DSS-Maternal Fetal Infant Workgroup and Substance Use Disorder and Social Determinants of Health sub-workgroups, the Uplift Connection, the MFFH Maternal Mortality Stakeholder group, the Maternal Mortality Working Group with Dr. Karen Florio, the Kansas City Perinatal Recovery Collaborative, and the DSS MO HealthNet Division Maternal Health Coordination Meetings.

Perinatal/Infant Health

National Performance Measures

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding
Indicators and Annual Objectives



NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			85.2
Annual Indicator	84.0	83.1	84.8
Numerator	55,547	54,118	53,369
Denominator	66,118	65,137	62,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			85.2
Annual Indicator	83.1	84.8	84.8
Numerator	54,118	53,369	53,369
Denominator	65,137	62,925	62,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	86.4	87.6	88.8	90.0

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			41.9
Annual Indicator	39.9	40.3	37.1
Numerator	25,485	25,609	23,096
Denominator	63,920	63,599	62,314
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			41.9
Annual Indicator	40.3	37.1	37.1
Numerator	25,609	23,096	23,096
Denominator	63,599	62,314	62,314
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.9	46.0	48.0	50.0

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			49
Annual Indicator	48.7	55.0	54.6
Numerator	31,408	35,105	33,976
Denominator	64,465	63,808	62,273
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			49
Annual Indicator	55	54.6	54.6
Numerator	35,105	33,976	33,976
Denominator	63,808	62,273	62,273
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.2	49.5	49.7	50.0

Evidence-Based or –Informed Strategy Measures

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			83.6
Annual Indicator	83.3	91.8	76.6
Numerator	234	202	108
Denominator	281	220	141
Data Source	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	83.8	84.0	84.6	85.0

State Action Plan Table

State Action Plan Table (Missouri) - Perinatal/Infant Health - Entry 1

Priority Need

Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

NPM

NPM 5 - A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Objectives

By 2025, Increase the percent of infants placed to sleep on their backs from 84.0% (2018 PRAMS).

By 2025, Increase the percent of infants placed to sleep on a separate approved sleep surface from 39.9% (2018 PRAMS).

By 2025, Increase the percent of infants placed to sleep without soft objects or loose bedding from 48.7% (2018 PRAMS).

Strategies

Distribute information and education about sleep-related infant deaths.

Support programs that provide cribs for low-income families.

Collaborate with partners to distribute safe sleep resources to low-income families.

Assess baseline and post-intervention safe sleep practices among program participants and families.

Partner with community service providers and other agencies to conduct trainings on infant safe sleep that target parents, child care providers, grandparents, home health care professionals, staff of obstetric and pediatric clinics, retailers, and faith-based organizations.

Facilitate partnerships with other state agencies, hospitals, nonprofits, media, and other stakeholders to develop innovative programs and policies that promote safe infant sleep, reduce infant mortality, encourage smoking cessation, and promote breastfeeding, immunizations, and prenatal care.

Build program and policy evaluation capacity.

ESMs

Status

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment. Active

NOMs

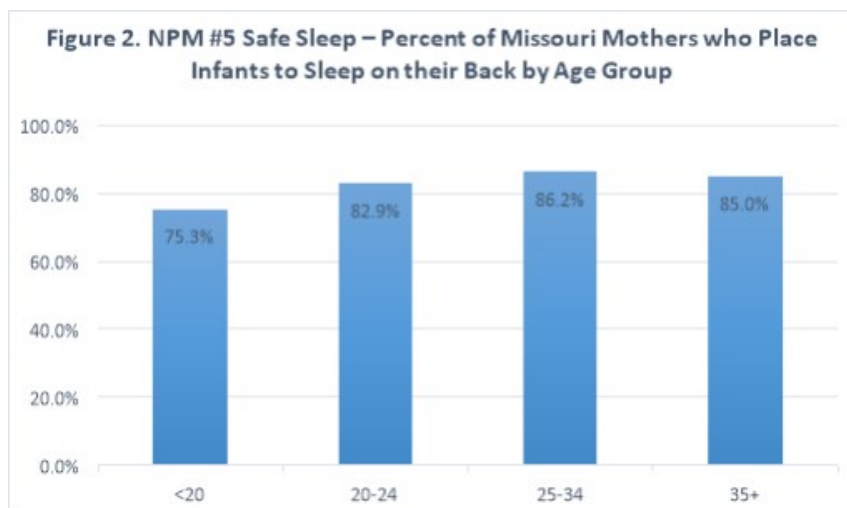
NOM 9.1 - Infant mortality rate per 1,000 live births

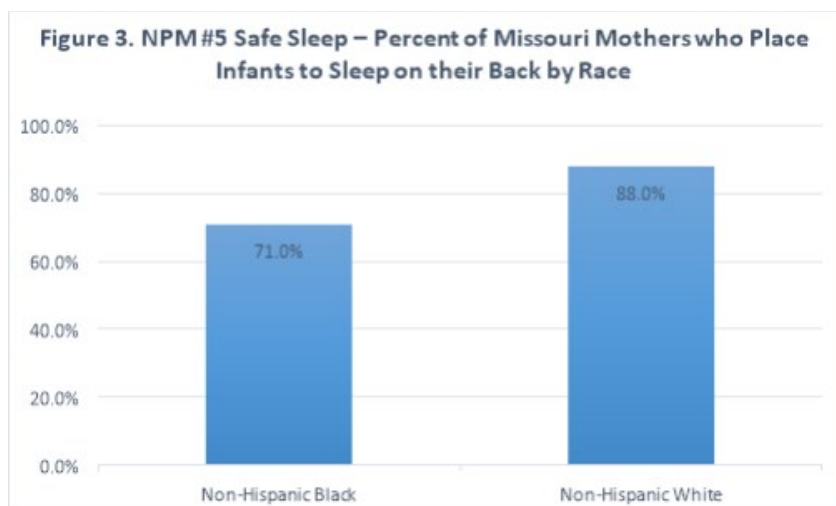
NOM 9.3 - Post neonatal mortality rate per 1,000 live births

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

NPM #5 Safe Sleep – Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

According to the American Academy of Pediatrics (AAP), throughout the first year of life, sleeping babies die accidentally from: suffocation, smothering, wedging, being trapped under someone else while sharing a bed, being placed to sleep on a surface not intended for an infant, and Sudden Infant Death Syndrome (SIDS). Infant deaths due to unsafe sleep practices continue to be a significant contributor to infant deaths in the US and Missouri. The AAP has issued evidence-based recommendations for a safe infant sleep environment. The recommendations are based on epidemiologic case-control studies of infants up to one year of age. Even though Safe Sleep was not selected as a top priority during the 2016-2020 needs assessment, Missouri selected the percent of infants placed to sleep on their backs as a State Performance Measure. According to the 2020 Pregnancy Risk Assessment Monitoring System (PRAMS), there was a 7.48% increase in Missouri mothers (84.8%) who placed infants to sleep on their backs from 2016. This exceeded the HP2020 goal of 75.9% and was higher than the 2020 overall rate (79.5%) for PRAMS sites*. PRAMS data indicate younger mothers are less likely to commonly place babies to sleep on their backs (Figure 2). Though there was a racial difference for 2020 (Figure 3), there was a 5.8% increase from the 2019 percentage for Non-Hispanic Black women (65.2%). College graduates were the highest proportion of mothers who laid infants to sleep on their back (89.9%). Those with private insurance had a higher percentage of infants placed to sleep on their backs (89.5%) than those on Medicaid (80.4%). Continued education and outreach is needed to increase awareness among mothers and caregivers who are not practicing safe sleep.





Safe Sleep Initiatives

Resources

The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide to implement and facilitate accomplishment of common goals and objectives concerning childhood injury prevention. BCHW provided funding for 10 Safe Kids (SK) coalitions that serve 59 counties. All 10 coalitions provided unintentional injury prevention services to children aged 0-19 years. The SK coalitions are led by a variety of agencies including local public health agencies (LPHAs), non-profit entities, and local hospital systems. The SK coalitions address priorities including crib safety and safe sleep based on community needs. The SK coalitions worked closely with law enforcement officers, fire fighters, paramedics, medical professionals, educators, businesses, public policy makers, and most importantly parents, children, and adolescents. Through this network, more than 450 cribs were provided along with AAP safe sleep education and training. In addition, 126 safe sleep events and trainings were held to reduce the risk of infant injury or death due to unsafe sleep environments. These events and trainings reached more than 1,300 participants such as expectant parents, new parents, caregivers, relatives (such as grandparents), foster parents, first responders, and public safety officers. The SK coalitions continued to conduct media campaigns with safe sleep promotion messages and work with policy makers to address gaps in policies that could prevent safe sleep injuries. These activities were supported with Title V MCH Block Grant funds and other funding sources.

SSM Health Cardinal Glennon Children's Hospital, the site of the SK Coalition in St. Louis, provided a one-hour Safe Sleep Training developed by the co-chairs of the SSM Health Safe Sleep Champion committee. Over 1,000 first responders, including law enforcement, health care providers, first responders, emergency medical services personnel, firefighters, and other public safety professionals received training on evidence-based infant safe sleep recommendations. The training was available in-person and virtually through Cardinal Glennon's Arlo training website. As first responders respond to many non-emergent situations, they can assess potential unsafe sleep environments if a child's home. The goal of the training was for first responders to understand the importance of infant safe sleep, have the knowledge needed to identify an unsafe sleep environment and be able to provide evidence-based safe sleep education to caregivers in the communities they serve. The ultimate goal was to prevent tragic infant loss related to unsafe sleep practices. Pediatric residents, advanced practice nurses and all new employees at SSM Health Cardinal Glennon Children's Hospital were also trained as Safe Sleep champions.

In addition to training healthcare providers, first responders, and public safety professionals, the Cardinal Glennon Safety programs offered monthly *Baby Safety 101!* classes for caregivers and monthly virtual infant CPR classes where safe sleep education was provided. Cardinal Glennon also partnered with community agencies to provide the

Baby Safety 101! classes within the community in an effort to reduce barriers for the most vulnerable populations. Upon completion of the class, if the caregiver needed a safe sleep environment but lacked the means to purchase one, it was provided at no cost. The safe sleep environment included a portable play yard, fitted crib sheet, sleep sack, bulb suction syringe, pacifier, and the “*Sleep Baby Safe and Sound*” book by Charlie’s Kids Foundation. Caregivers were also provided a bag of home safety resources and an informational folder on safe sleep.

The Title V MCH and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) funded home visiting services, organized in the Department of Elementary and Secondary Education (DESE), Office of Childhood (OOC), were offered in 26 counties and served 1,008 families in FY21 through four evidence-based home visiting models:

- Nurse Family Partnership;
- Healthy Families America;
- Parents as Teachers; and
- Early Head Start Home Based Option.

All Title V MCH funded Home Visiting Program contracted home visitors actively promoted and provided resources on the ABCs (**A**lone, on their **B**ack, in a **C**rib) of Safe Sleep. Home visitors also promoted safe sleep for families who did not have and could not afford a crib by obtaining portable cribs through the Safe Cribs for Missouri program or other local resources. The Home Visiting Program continued to update and provide all contracted home visitors with information on how to obtain portable cribs and create safe sleep environments as recommended by the AAP. This information was shared with contracted home visiting agency staff for distribution to enrolled families through a variety of ongoing communication including: postings within the continuous quality improvement Missouri Home Visiting Gateway Website on the Home Visiting Program’s web-based data collection system platform, the *Weekly Update* emailed to each contracted home visitor and supervisor, monthly subrecipient monitoring calls with contracted agencies, and during annual home visiting professional development events.

The Home Visiting Program collects data on the percentage of infants enrolled in home visiting who are always placed to sleep on their backs, without bedsharing, or without soft bedding. This data is collected at birth and up to twelve months of age. In FY21, the combined percentage was 78.6% (217/276). The Home Visiting Program included articles, webinars, and other resources on safe sleep in seven Weekly Updates on 10/2/20, 10/9/20, 10/30/20, 12/11/20, 1/29/21, 6/4/21, and 6/18/21. Safe sleep was also promoted in the first quarter Home Visiting Program’s continuous quality improvement Newsletter, *Quality Outlook*, during SIDS Awareness Month.

The Safe Cribs for Missouri Program provided portable cribs and safe sleep educational resources to participating agencies. In addition to the National Institute of Child Health and Human Development SIDS risk reduction online education program, the Safe Cribs for Missouri Program continued to evaluate and provide access to other evidence-based resources for safe sleep educators. All education programs and resources complied with the evidence-based AAP safe sleep recommendations. The Safe Cribs for Missouri Program also continued to collaborate with the Department of Social Services (DSS)-Children’s Division (CD), the DSS Child Fatality Review Program and the Children’s Trust Fund (CTF) to develop part 2 of the online safe sleep training for CD staff who work directly with families. As a member of the States Safe Sleep Coalition, the program continued to collaborate with CTF, CD, Infant Loss Resources, Inc., pediatric hospitals, and other coalition members to implement the new strategic plan to reduce sleep-related infant deaths. The strategic plan was developed with the guidance of the National Institute for Children’s Health Quality.

The Safe Cribs for Missouri Program continued to work with Safe Sleep Coalition partners to provide safe sleep education and technical assistance to hospitals. Resources included the new safe sleep video, the “This Side Up While Sleeping” t-shirt, and other educational materials available from the DHSS at no charge. In addition,

information about the National Safe Sleep Hospital Certification Program was provided. The Safe Cribs for Missouri Program also continued to collaborate with the Safe Sleep Coalition partners to develop a way to recognize hospitals that achieve National Safe Sleep Certification.

The TEL-LINK Program helped improve MCH by providing health care service referrals to increase access to care for any Missourian who needs assistance. The program promoted this service through search engine campaigns to provide outreach to the underserved population. TEL-LINK provided referrals to a wide range of services related to safe sleep including safe crib providers, WIC clinics, child care facilities, and many more.

The MCH Services Program continued to contract with five LPHAs that selected the priority health issue to promote safe sleep practices among newborns to reduce sleep-related infant deaths.

- Benton County Health Department implemented a Safe Cribs Program that provided a safe sleep environment and education to parent(s). This resulted in an increase in the number of infants placed to sleep on an approved sleep surface as well as an increase in the number of infants placed to sleep on their backs.
- Scott County Health Department collaborated with the WIC program to implement a safe sleep survey to be administered to WIC participants that were either at 35 weeks gestation or more or had an infant up to 3 months of age. The Safe Cribs Missouri Program paired with safe sleep education was implemented to promote safe sleep practices. This resulted in an increase in the number of infants placed to sleep on an approved sleep surface as well as an increase in the number of infants placed to sleep on their backs.

The DHSS continued to participate in the Maternal and Child Learning and Action Network (MC LAN) to assist with implementation of infant morbidity/mortality reduction initiatives throughout the state. The MC LAN launched a Missouri Neonatal Abstinence Syndrome (NAS) collaborative in year 2021, which coincided with implementation of the Obstetric Care for Women with Opioid Use Disorder. Throughout the next two years, participating organizations are focusing on changing the model of care for substance-exposed newborns, including: supporting the mother-infant dyad and the mother as “medicine;” incorporating the functional assessment model *Eat, Sleep, Console* into practice, establishing Safe Plans of Care for the mother and infant, and accessing training on stigma and bias reduction. Similar to the maternal projects through the MC LAN, participating hospitals will be required to submit data through MHA for progress and outcomes monitoring.

The Mothers, Infants and NAS ECHO (Extension for Community Healthcare Outcomes) was created by the University of Missouri’s Telehealth Network and the Missouri Hospital Association to support rural health care providers in caring for the mother-infant dyad with substance exposure. The ECHO started in FY21, regularly occurs bi-monthly for one hour, and includes a brief didactic presentation, sharing of case studies, and discussion with a multi-disciplinary panel of experts for enhanced collaborative learning. The MCH Director and Maternal/Infant Mortality Coordinator participated in the EHCO. The objectives of the ECHO are to:

- Improve identification of mother-infant dyads affected by substance use disorder (SUD) by implementing validated screening techniques, guidelines and referrals;
- Support implementation of the Eat, Sleep, Console (ESC) non-pharmacologic care model for optimal health and psychosocial outcomes;
- Provide guidance for use of pharmacologic interventions for infants with in-utero exposure from maternal substance use;
- Identify a framework to connect hospitals with internal and external support/resources for the mother-infant dyad; and
- Ensure mothers with SUD receive appropriate pain and withdrawal assessment and treatment after delivery to stabilize symptoms, promote recovery, and support optimal family function.

Collaboratives

The MCH Director, MCH Services Program team, and Office on Women's Health (OWH) continued to participate in, as well as be a resource for the local and regional infant mortality initiatives, including Generate Health and FLOURISH in St. Louis, Nurture KC in Kansas City, and the Missouri Bootheel Regional Consortium (MBRC)- Bootheel Babies & Families initiative in the southeast region of the state. Nurture KC and MBRC are the two Healthy Start Grantees in Missouri.

- St. Louis: Generate Health's initiatives focused on five strategic priorities, including: health equity, maternal and infant health, perinatal behavioral health, immunizations, and making change happen. With Generate Health as a backbone organization, FLOURISH is a collective impact initiative aimed at making St. Louis a place where healthy babies and families flourish. FLOURISH focused on six priority issues: coordinated quality care, safe sleep, housing, transportation, home visitation and behavioral health.
- Kansas City: Nurture KC's focus was on traditionally low-income families residing in hard to reach neighborhoods. They have a special emphasis on cultural competency and strive to help people of all racial, ethnic, and socio-economic backgrounds. Nurture KC had a special focus on safe sleep and coordinated the Safe Sleep Task Force, a group of committed volunteers working to reduce infant deaths through education on safe sleep practices. Nurture KC also provided eligible families with cribs.
- Southeast Missouri: Bootheel Babies & Families had three key focus areas including healthcare, safe sleep habits, and substance misuse. Unsafe sleep was the primary cause of infant mortality in that region of the state. They also continued to organize and host the annual low birth weight conference, bringing together community members, partners, and organizations, as well as national speakers.

Child Care Providers

The Department of Elementary and Secondary Education (DESE), Office of Childhood (OOC), Compliance Section is responsible for licensing and regulating child care programs. Through ongoing regulatory inspections, the OOC continued to verify compliance with licensing rules regarding infant safe sleep. The OOC educated child care providers about infant safe sleep practices through technical assistance and training. Section 210.223.4, RSMo requires all employees of licensed child care facilities who care for infants under one year of age, and any volunteer who may be assisting at the facility to successfully complete department-approved training on the most recent AAP safe sleep recommendations prior to initial licensure, within their first 30 days of employment, and every three years thereafter. The OOC continued to review and approve safe sleep training, and ensure training is available via a variety of delivery systems in order to increase licensed child care providers' knowledge of infant safe sleep practices. During child care inspections, OOC-staff reviewed training records to ensure all required staff and volunteers had successfully completed department-approved trainings on safe sleep for infants within the required timeframes. Child care providers are required to share their approved safe sleep plan that meets the AAP guidelines with families upon enrollment. By providing new families with the policy that meets the current AAP guidelines, child care providers were able to further advance the educational outreach to families with infants.

The Child Care Health Consultation (CCHC) Program continued to assist licensed child care providers in meeting the safe sleep training requirement set forth in the Missouri Revised Statute 210.223.4, and continued to provide training and consultation regarding safe sleep practices to both regulated and unregulated child care facilities. Consultants provided 27 hours of department-approved safe sleep training and 5 hours of consultation related to safe sleep practices, policies, and procedures for child care facilities. As a result of the trainings, the CCHC Program reported increases in the proportion of:

- Child care providers and community partners (LPHAs) that provided safe sleep trainings to parents/guardians and child care providers in both regulated and unregulated child care environments;
- Child care providers that reported increased knowledge of safe sleep practices, including importance of having infants placed to sleep on their backs, having infants placed to sleep on safety approved sleep

- surfaces, and having infants placed to sleep without soft objects or loose bedding;
- Distributed educational materials about sleep-related infant deaths and safe-sleep practices to child care providers and parents/guardians of children in child care; and
- Child care providers with increased knowledge regarding which infants and home environments place infants at the highest risk for unsafe sleep environments and sleep related deaths.

The capacity of LPHAs to deliver CCHC Program services was severely impacted by the ongoing COVID-19 pandemic. The CCHC Program encouraged family attendance during program trainings and consultation, increasing access to evidence-based information regarding safe sleep practices for child care providers and families. The CCHC Program also provided training for child care providers to help them address parent/guardian concerns with safe sleep procedures implemented in the child care setting.

Breastfeeding

Hospitals

The State Breastfeeding Coordinator continued to collaborate with the Missouri Breastfeeding Coalition on statewide initiatives, including the Missouri “Show-Me 5” Hospital Initiative and the Missouri Breastfeeding Friendly Worksite and Child Care programs. In collaboration with BCHW, the Missouri breastfeeding coordinator hosted a series of eight webinars with speakers from Missouri Baby Friendly hospitals to encourage other hospitals to implement the Missouri “Show-Me 5” and Baby Friendly Hospital practices. These webinars took the place of the MotherBaby Summit, which was canceled due to Covid-19 and staffing changes. Funds from the State Physical Activity and Nutrition (SPAN) grant from the Centers for Disease Control and Prevention (CDC) were leveraged to support the webinars. Webinar participants reported that they found the series helpful as a way to learn from their colleagues in other hospital systems and motivate hospital administrators to make positive policy changes. The Missouri Breastfeeding Coalition Board identified lactation training for nursing staff as a major need in Missouri and an important barrier to Baby Friendly Hospital designation. Statewide training for all health care providers in Missouri continued with the ultimate goal to increase the number of International Board Certified Lactation Consultants (IBCLCs) in the state. Basic and advanced lactation training was offered at no cost to WIC local agency staff, hospital nurses working with new mothers and infants, and community partners working with breastfeeding mothers, including three intermediate virtual courses and one advanced virtual course. The department conducted a survey in 2021 of participants who had taken this course in 2019 and 2020 and found that out of 38 respondents, 16 planned to become an IBCLC, and 11 of those reported that they sat for and passed the exam after taking the course. It normally takes several years for a person to achieve the goal of becoming an IBCLC, and the department is very pleased to report these results.

Local Public Health Agencies (LPHAs)

BCHW, through Preventive Health and Health Services Block Grant funds, will assist LPHAs in building their capacity to achieve policy and environmental changes that increase access to healthy foods (including breastfeeding support). The primary objective of services provided by contractors is to increase the capacity of community coalitions within their service area to make measurable improvements in chronic disease related health outcomes.

The Missouri WIC Program provided additional funding through the Breastfeeding Friendly WIC Clinic Program to 53 local WIC agencies that provided breastfeeding support beyond what is federally required through the WIC program, which included providing after hours support, classes, support groups, breast pumps and working with other community partners to increase breastfeeding awareness. The state also provided education to local WIC agencies and health department professionals on breastfeeding and worked to increase the number of IBCLCs

and trained peer counselors that provided mother-to-mother support in these facilities. They also encouraged partnerships with health care providers and other community organizations. Many of the local agency staff who work in WIC also partner with or work directly on MCH initiatives, and serve many of the same participants.

The MCH Services Program supported LPHA efforts to promote breastfeeding initiation at birth and continuation of exclusive breastfeeding through the first six months of life, and continuation of breastfeeding as long thereafter as mother and child desire, including:

- provision of breastfeeding peer counseling;
- breastfeeding support groups;
- individual, community, and provider education;
- breast pump loan programs; and
- promotion of breastfeeding friendly worksites and child care centers

Breastfeeding Friendly Sites

BCHW partnered with the Missouri Chamber of Commerce, the Missouri Chapter of Society of Human Resource Managers, and the Missouri Council for Activity and Nutrition's Worksites workgroup to educate employers on the Affordable Care Act (ACA) provision for employers to provide workplace accommodations that enable breastfeeding employees to express breast milk. DHSS continued to recognize employers achieving criteria for the Missouri Breastfeeding Friendly Worksite program. Many local breastfeeding coalitions and LPHA WIC peer counselors continued outreach to businesses about the importance of worksite lactation support. This outreach was hampered by the difficulty of contacting businesses in person during the pandemic and by limits on staff time, as many staff were pulled away from normal duties to respond to the pandemic.

Collaboration continued with the Missouri Breastfeeding Coalition and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Program. Similar to the "Breastfeeding Friendly Worksite Award," the "Breastfeeding Friendly Child Care" award recognizes child care facilities who meet advanced criteria on breastfeeding support. The CCHC Program provided consultation and continuing education training to child care providers that promote child care facilities as breastfeeding friendly; both for parents of children enrolled who are breastfeeding, and as a breastfeeding friendly workplace for employees who are breastfeeding. LPHAs utilize the CCHC program as a partner in promoting the Breastfeeding Friendly Worksite award and as an important source of training. An online training is available for this program due to high provider demand. Both of these award programs are low cost, efficient, and provide a realistic means to sustain support for breastfeeding families.

Partnering with Child Care Aware, the "Breastfeeding Friendly Child Care" award, and corresponding online training was promoted and those who meet the criteria to earn the award distinction were recognized. Plans to further promote the award to parents and providers are being implemented. DHSS and Missouri Council for Activity & Nutrition (MOCAN) ensured that these two awards are highlighted during all worksite wellness outreach efforts. The MOCAN worksites workgroup encourages businesses to implement a wellness program for their staff. The WorkWell Missouri Toolkit was developed to assist employers with reducing risk factors for chronic diseases, poor nutrition (including breastfeeding support), inactivity, stress, and tobacco use. The Toolkit is designed to help organizations assess and improve workplace wellness policies and practices. MOCAN members promote this toolkit as well as partner with organizations assisting businesses in the state to improve health.

Resources for Parents

The Bureau of Genetics and Healthy Childhood (GHC) Newborn Health Program participated in statewide educational activities to increase awareness and promote recommended MCH practices, including breastfeeding. The Newborn Health Program also provided Missouri's prenatal and newborn health book, *Pregnancy and Beyond*,

free of charge. Additionally, the program provided other educational literature to raise awareness and educate Missourians on the importance of breastfeeding and direct the public to resources that assist with breastfeeding. In addition to print materials, the Newborn Health Program maintained websites that provided electronic access to similar breastfeeding information/resources. Approximately 24,000 books were distributed in FY21. Starting in FY2022, the program will track the distribution of these materials and obtain feedback from its partners on how the materials are used and ways to improve the materials.

The Title V MCH funded Home Visiting Program's contracted home visitors provided education, resources, and support to enrolled prenatal participants to promote breastfeeding initiation and sustained duration. Annual performance measure data was collected on the percent of infants who were breastfed any amount at 6 months of age among mothers who enrolled in home visiting prenatally. In FY21, this percentage was 8.9% (6/67). During FY 2021, the CQI State Priority Focus was to improve on this rate through Plan-Do Study Act (PDSA) projects each contracting agency has been completing. Due to the necessity for visits to be virtual much of this timeframe, the same priority focus is being continued for 2022 through 2023 to allow "in-person" support by home visitors. The Home Visiting Program included articles, webinars, and other resources on breastfeeding in four Weekly Updates on 10/2/20, 11/13/20, 4/2/21, and 8/20/21. Breastfeeding Awareness Month was promoted in the fourth quarter *Quality Outlook* newsletter. The Home Visiting Program addressed home visitors' breastfeeding technical assistance needs through monthly subrecipient monitoring and provided resources and training opportunities through ongoing communication. Collaboration with the State Breastfeeding Coordinator and the Home Visiting Program continued to assure up to date information, training opportunities, and support for all contracted home visitors.

Other Title V Program Activities Related to the Perinatal-Infant Health Domain

Count the Kicks

In FY18, the Newborn Health Program partnered with Healthy Birth Day, Inc. to implement and operate a Count the Kicks Public Awareness Campaign program to support pregnant women and reduce stillbirth rates in Missouri. According to the CDC, Missouri has the 18th highest stillbirth rate in the country. Missouri vital statistics show there are approximately 353 stillborn births each year. The continued use of Count the Kicks has the potential to save 91 babies every year if Missouri's stillbirth rate decreases by 26 percent, as has happened in neighboring Iowa where the campaign began. Count the Kicks teaches the method and importance of counting baby's kicks in the third trimester of pregnancy. Free educational materials can be ordered from Count the Kicks at <https://www.countthekicks.org/order-materials/>. The Newborn Health Program continued to partner with a wide range of community health partners to promote Count the Kicks. The program hosted webinars to equip home visitors with tools to teach their clients how to count kicks. The program was also promoted at OB/GYN clinics and birthing hospitals.

Newborn Screening

The Newborn Screening Program continued to work to increase awareness of newborn screening with the goal of ensuring all newborns have access to newborn screening shortly after birth, thereby reducing the risk of mortality/morbidity related to undiagnosed and untreated metabolic, genetic, and endocrine disorders. Missouri law requires all babies born in the state to be screened for over 70 different disorders including hearing loss and critical congenital heart disease. The Program continued to work with the Missouri Midwives Association and the Amish and Mennonite communities to provide education and technical assistance when needed.

Neonatal Abstinence Syndrome (NAS)

Missouri participated in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community to advance policy implementation to equitably address substance misuse and

addiction and mental health disorders in women, children, and families within the context of the COVID-19 pandemic. Missouri's participation in the PRISM Learning Community provided the conceptual frame for the development of a state action plan to address the impact of maternal substance use and mental health issues on the mother-infant dyad. The state action plan included strategies to leverage Missouri's existing maternal-fetal-infant/neonatal abstinence syndrome (MFI/NAS) workgroups, including the NAS Stakeholder Workgroup previously facilitated by the DHSS, to organize a statewide Maternal Multisector Action Network to coordinate and collaborate on maternal mental health and substance use prevention and treatment efforts and advance policy proposals to promote maternal mental health and substance use prevention and treatment.

Oral Health

The ODH continued to educate mothers about the importance of oral health for their overall health and well-being. This was accomplished via continued collaboration with the Missouri Primary Care Association (MPCA) to provide education to women about the importance of dental visits during pregnancy. As quantity allowed, ODH supplied infant toothbrushes and *Healthy Smiles from the Start* booklets to the St. Louis Safe Kids Coordinator for use during baby safety classes. The baby safety classes covered safe sleep habits, car seat safety, breast and bottle-feeding and oral care. The training reached pregnant moms, new parents and grandparents and was presented in both English and Spanish.

Injury Prevention

From January 1, 2021 thru September 30, 2021, SSM Health Cardinal Glennon Children's Hospital (Safe Kids St. Louis) provided approximately 338 injury prevention consultations to patients and families. Healthcare providers entered an injury prevention consult order into the electronic medical record (EMR) based on results of safety assessments. During the safety assessment, the physician was required to ask parents about sleeping concerns for any child under the age of one. After the assessment, one-on-one safe sleep education was provided by a member of the safety program. A safe sleep environment was provided at no cost, including a portable play yard, fitted crib sheet, sleep sack, bulb suction syringe, pacifier, and the "*Sleep Baby Safe and Sound*" book by Charlie's Kids Foundation. Documentation in the patient's medical record was completed by the injury prevention team member who provided the education and resources. The injury prevention consult was not exclusive to infant safe sleep. The consult also included safety education and resources for all unintentional injury risk areas, including car seat safety, gun locks, medication lock pouches, home & water safety resources, such as and bike safety.

The Safe Kids St. Louis coordinator, who is also the Injury Prevention Nurse Coordinator at SSM Health Cardinal Glennon Children's Hospital, is the instructor of the Infant Safe Sleep training. A firefighter/paramedic reported the Infant Safe Sleep training may have saved an infant's life. The firefighter/paramedic's crew responded to a local extended stay hotel to care for a female with abdominal pain. Upon arrival, the crew noted a mom, dad, and infant were staying in the room, and the first responders asked where the child was sleeping. The parents reported the child was sharing the bed with them. After transporting the mother to the hospital, the first responders returned to their engine house to get a pack-n-play crib and delivered it to the family. The family was very grateful and said they would use it moving forward. The Safe Kids St. Louis coordinator reported there have been at least two previous pediatric cardiac arrests at the same hotel, including a child that was sleeping in the same bed as the parents.

* Includes Alabama, Alaska, Arkansas, Colorado, Connecticut, Delaware, District of Columbia, Florida, Georgia, Hawaii, Illinois, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, New York City, New York State, North Carolina, North Dakota, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Dakota, Tennessee, Utah, Vermont, Virginia, Washington, Wisconsin, and Wyoming.

Perinatal/Infant Health - Application Year

NPM #5 Safe Sleep – Promote safe sleep practices among newborns to reduce sleep-related infant deaths.

Safe Sleep Initiatives

Resources

The Bureau of Community Health and Wellness (CHW) serves as the state lead for Safe Kids Worldwide to implement and facilitate accomplishment of common goals and objectives concerning childhood injury prevention. BCHW also provides funding to 10 Safe Kids (SK) coalitions that serve 60 counties. All 10 coalitions provide unintentional injury prevention services to children aged 0-19 years. The SK coalitions are led by a variety of agencies, including local public health agencies (LPHAs), non-profit entities, and local hospital systems. The SK coalitions address injury prevention priorities such as crib safety and safe sleep based on community needs. The SK coalitions will continue to provide cribs and safe sleep education to parents/caretakers, conduct media campaigns with safe sleep promotion messages, and work with policy makers to address gaps in policies that could prevent safe sleep injuries. The SK coalitions will continue to work closely with law enforcement officers, fire fighters, paramedics, medical professionals, educators, community agencies, businesses, public policy makers, and most importantly parents, children, and adolescents.

All Title V MCH funded Home Visiting Program contracted home visitors will actively promote and provide resources on the ABCs (**A**lone, on their **B**ack, in a **C**rib) of Safe Sleep. Home visitors will also promote safe sleep by obtaining portable cribs for families who do not have and cannot afford a crib for their infant through the Safe Cribs for Missouri program or other local resources. Annual performance measure data on safe sleep will be collected on the percentage of infants enrolled in home visiting who are always placed to sleep on their backs, without bedsharing and without soft bedding. This data will be collected at birth and will continue to be updated through twelve months of age. The Home Visiting Program will continue to update and provide all contracted home visitors with information on how to obtain portable cribs and create safe sleep environments as recommended by the American Academy of Pediatrics (AAP). This information will continue to be shared with contracted home visiting agency staff for distribution to enrolled families through a variety of ongoing communication including: postings within the continuous quality improvement Missouri Home Visiting Gateway Website located on the Home Visiting Program's web-based data collection system platform, the *Weekly Update* emailed to each contracted home visitor and supervisor; monthly subrecipient monitoring calls with contracted agencies; and during annual home visiting professional development events.

The Safe Cribs for Missouri Program in the Department of Elementary and Secondary Education (DESE) Office of Childhood (OOC) provides portable cribs and safe sleep educational resources to participating agencies. The program will continue to partner with the Department of Health and Senior Services (DHSS), Children's Trust Fund (CTF) and Safe Sleep Coalition partners to provide current educational resources to promote SIDS risk reduction and safe sleep environments and practices. Updated DHSS warehouse ordering information will be provided annually to agencies contracting with the Safe Cribs for Missouri Program. All education programs and resources will continue to comply with the evidence-based AAP safe sleep recommendations. As a participating member in the statewide Safe Sleep Coalition, facilitated by CTF, the Safe Cribs Program will collaborate with CTF, the Department of Social Services (DSS) - Children's Division (CD), Infant Loss Resources, Inc., pediatric hospitals, and other Coalition members to promote implementation of the Coalition's strategic plan. The strategic plan was developed with the guidance of the National Institute for Children's Health Quality to achieve the overall goal of reducing sleep-related infant deaths.

The Safe Cribs for Missouri Program will continue to partner with the Safe Sleep Coalition to provide safe sleep

education and technical assistance to hospitals. Resources will include the new safe sleep video, the “This Side Up” t-shirt, and other educational materials available from the DHSS at no charge. The Safe Cribs for Missouri Program will also continue to collaborate with Safe Sleep Coalition to support recognition of hospitals that have achieved National Safe Sleep Certification. In order for a hospital to achieve certification they must develop a safe sleep policy, train their healthcare team members on safe sleep practices, provide safe sleep education to family members and/or caregivers, provide safe sleep education on their hospital website, and display safe sleep imagery throughout their hospitals. Hospitals meeting the requirements can contact Cribs for Kids to request a virtual site visit and finish the application process.

The TEL-LINK Program will continue to provide health care service referrals to increase access to care for any Missourian who needs assistance. The program promotes this service through search engine campaigns to provide outreach to underserved populations. TEL-LINK provides referrals to a wide range of services, such as safe crib providers, WIC clinics, audiologists, car seat providers, child care facilities, and many more.

The MCH Services Program will continue to contract with the seven LPHAs that selected promoting safe sleep practices among newborns to reduce sleep-related infant deaths as a priority health issue.

- The Vernon County and Cole County Health departments will collaborate with the WIC office to screen participants who are 32+ weeks gestation and/or have an infant up to one year of age for safe sleep status and risk. Those identified in need will be provided a pack-n-play, safe sleep education and a Safe Sleep Survival kit. The Safe Sleep Survival kit was designed using the national Cribs for Kids program as a model and includes a Philips Soothie Pacifier, HALO Sleep Sack, and a fitted crib sheet.
- The Crawford County Health Department will collaborate with the WIC office using the Safe Cribs Missouri program to screen participants for safe sleep status and risk and provide a pack-n-play and safe sleep education to those identified in need.

The DHSS will continue to participate in the Maternal and Child Learning and Action Network (MC LAN) to assist with implementation of infant morbidity/mortality reduction initiatives throughout the state. The MC LAN launched a Missouri Neonatal Abstinence Syndrome (NAS) collaborative in year 2021, which coincided with implementation of the Obstetric Care for Women with Opioid Use Disorder. Throughout the next two years, participating organizations will focus on changing the model of care for substance-exposed newborns, including supporting the mother-infant dyad and the mother as “medicine;” incorporating the functional assessment model Eat, Sleep, Console into practice; establishing Safe Plans of Care for the mother and infant; and accessing training on stigma and bias reduction. Similar to the maternal projects through the MC LAN, participating hospitals will be required to submit data through MHA for progress and outcomes monitoring.

The Mothers, Infants and NAS ECHO (Extension for Community Healthcare Outcomes), created by the University of Missouri’s Telehealth Network and the Missouri Hospital Association to support rural health care providers in caring for the mother-infant dyad with substance exposure, The MCH Director and Maternal/Infant Mortality Coordinator will continue to participate in the bi-monthly ECHO to:

- Improve identification of mother-infant dyads affected by substance use disorder (SUD) by implementing validated screening techniques, guidelines and referrals;
- Support implementation of the Eat, Sleep, Console (ESC) non-pharmacologic care model for optimal health and psychosocial outcomes;
- Provide guidance for use of pharmacologic interventions for infants with in-utero exposure from maternal substance use;
- Identify a framework to connect hospitals with internal and external support/resources for the mother-infant dyad; and

- Ensure mothers with SUD receive appropriate pain and withdrawal assessment and treatment after delivery to stabilize symptoms, promote recovery, and support optimal family function.

Collaboratives

The MCH Director, MCH Services Program team, and Office on Women's Health will continue to participate in, as well as be a resource for, the local and regional infant mortality initiatives, including Generate Health and FLOURISH in St. Louis, Nurture KC in Kansas City, and the Missouri Bootheel Regional Consortium Bootheel Babies & Families initiative in the southeast region of the state. Nurture KC and Missouri Bootheel Regional Consortium are also the two Healthy Start Grantees in Missouri.

- St. Louis: Generate Health's initiatives will focus on five strategic priorities, including: health equity, maternal and infant health, perinatal behavioral health, immunizations, and making change happen. FLOURISH St. Louis works in coordination with Generate Health. FLOURISH is a collective impact initiative aimed at making St. Louis a place where healthy babies and families flourish. FLOURISH focuses on six priority issues: coordinated quality care, safe sleep, housing, transportation, home visitation and behavioral health.
- Kansas City: Nurture KC's focus is on traditionally low-income families who reside in hard to reach neighborhoods in Missouri and Kansas. They have a special emphasis on cultural competency and strive to help people of all racial, ethnic, and socio-economic backgrounds. Nurture KC has a special focus on safe sleep and coordinates the Safe Sleep Task Force, a group of committed volunteers working to reduce infant deaths through education on safe sleep practices. Nurture KC also provides cribs to eligible families.
- Southeast Missouri: Unsafe sleep is the primary cause of infant mortality in the southeast region of the state. Bootheel Babies & Families has three key focus areas including healthcare, safe sleep habits, and substance misuse and will continue to organize and host the annual low birth weight conference to bring together community members, partners, organizations, and national speakers.

Child Care Providers

The DESE OOC Compliance Section is responsible for licensing and regulating child care programs. Through ongoing regulatory inspections, OOC will verify compliance with licensing rules regarding infant safe sleep. OOC will educate child care providers about infant safe sleep practices through technical assistance and training. Section 210.223.4, RSMo requires all employees of licensed child care facilities who care for infants under one year of age, and any volunteer who may be assisting at the facility to successfully complete department-approved training on the most recent AAP safe sleep recommendations prior to initial licensure, within their first 30 days of employment, and every three years thereafter. OOC will review and approve safe sleep training, and ensure training is available via a variety of delivery systems in order to increase licensed child care providers' knowledge of infant safe sleep practices. During child care inspections, OOC staff will review training records to ensure all required staff and volunteers have successfully completed department-approved trainings on safe sleep for infants within the required timeframes. Child care providers are required to share their approved safe sleep plan that meets the AAP guidelines with families upon enrollment. By providing new families with the policy that meets the current AAP guidelines, child care providers are able to further advance the educational outreach to families with infants.

The Child Care Health Consultation (CCHC) Program will continue to assist licensed child care providers in meeting the safe sleep training requirement set forth in the Missouri Revised Statute 210.223.4. Local Public Health Agency (LPHA) staff that provide CCHC Program services will also continue to provide consultation and training regarding safe sleep practices to child care providers at both regulated and unregulated child care facilities. Consultations will be provided regarding the assessment of the child care facility's policies regarding safe sleep, assessment of the implementation of safe sleep policies and procedures, and opportunities for continued evaluation and improvement of safe sleep practices. CCHC Program safe sleep trainings for child care providers will address the elements of safe sleep, such as the importance of placing infants to sleep on their backs, on separate safety-approved sleep

surfaces, and without soft objects or loose bedding on the sleep surface. These trainings will also increase provider knowledge regarding which infants are at highest risk and or which home environments place infants at the highest risk for unsafe sleep environments and/or sleep-related deaths. Trainings will also continue to assist child care providers in addressing parent/guardian concerns with safe sleep procedures implemented in the child care setting. Family attendance during CCHC program services will be encouraged, and evidence-based information and educational resources regarding safe sleep practices will also be provided to families. Educational materials about sleep-related deaths and safe sleep practices, including organizations to contact for access to free safe-sleep educational resources, will also be provided to child care providers and parents/guardians of infants in child care.

Breastfeeding

Hospitals

The State Breastfeeding Coordinator will continue to collaborate with the Missouri Breastfeeding Coalition on statewide initiatives, including the Missouri “Show-Me 5” Hospital Initiative and the Missouri Breastfeeding Friendly Worksite and Child Care programs. In collaboration with the Missouri Breastfeeding Coalition, the DHSS will host a series of webinars led by speakers from Missouri Baby Friendly hospitals, as well as national speakers, to encourage other hospitals to implement the Missouri “Show-Me 5” Hospital Initiative and Baby Friendly Hospital practices. These webinars will alternate between a speaking topic and networking session every other month, allowing hospitals working on improving maternity care practices to benefit from mentorship from staff at designated Baby Friendly hospitals. Funds from the State Physical Activity and Nutrition grant from the Centers for Disease Control and Prevention (CDC) will be leveraged to support the webinars. The Missouri Breastfeeding Coalition Board identified lactation training for nursing staff as a major need in Missouri. Lack of lactation training is also a barrier to Baby Friendly Hospital designation. Statewide training for all health care providers in Missouri will continue to increase the number of International Board Certified Lactation Consultants (IBCLCs) in the state. Basic and advanced lactation training will be offered at no cost to WIC local agency staff, hospital nurses working with new mothers and infants, and community partners working with breastfeeding mothers.

Local Public Health Agencies (LPHAs)

The Missouri WIC program will provide additional funding through the Breastfeeding Friendly WIC Clinic program to local WIC agencies that provide breastfeeding support beyond what is federally required through the WIC program. The additional support will include providing after hours support, classes, support groups, breast pumps and working with other community partners to increase breastfeeding awareness. The state will also provide education to local WIC agencies and health department professionals on breastfeeding and work to increase the number of IBCLCs in these facilities. Additionally, the state will work to increase the number of trained peer counselors that can provide mother-to-mother support and encourage partnerships with health care providers and other community organizations. Many of the local agency staff who work in WIC also partner with or work directly on MCH initiatives, and serve many of the same participants.

The MCH Services Program will support LPHA efforts to promote breastfeeding initiation at birth and continuation of exclusive breastfeeding through the first six months of life, and continuation of breastfeeding as long thereafter as mother and child desire. Planned efforts include:

- Provision of breastfeeding peer counseling;
- Breastfeeding support groups;
- Individual, community, and provider education;
- Breast pump loan programs; and
- Promotion of breastfeeding friendly worksites and child care centers.

The CCHC Program will continue to support LPHAs through consultations and trainings to promote breastfeeding practices in the child care setting. LPHA staff will provide consultations and trainings to child care providers to assist in the development and implementation of policies and procedures that: 1) encourage and support breastfeeding, 2) are welcoming and inclusive to all mothers including employees who breastfeed and 3) provide referrals to outside resources- such as WIC- when indicated. In addition, trainings will focus on safe handling and storage of breastmilk and the benefits of breastfeeding for both infants and mothers. As parent/guardian attendance during all program services is encouraged, evidence based information and educational resources and materials regarding breastfeeding will be provided to child care providers and families.

Breastfeeding Friendly Sites

BCHW will partner with the Missouri Council for Activity and Nutrition's (MOCAN) Worksites workgroup and other stakeholders to educate employers on the Affordable Care Act (ACA) provision for employers to provide workplace accommodations that enable breastfeeding employees to express breast milk. BCHW will continue to recognize employers achieving criteria for the Missouri Breastfeeding Friendly Worksite program. To receive the award, employers must address policy for breastfeeding support, educate expecting mothers on their breastfeeding policies, provide a private room appropriate for expressing milk, offer flexible scheduling and make breastfeeding resources available. Many local breastfeeding coalitions and LPHA WIC peer counselors will continue doing outreach to businesses about the importance of worksite lactation support.

The MOCAN worksites workgroup encourages businesses to start and implement a wellness program for their staff. The WorkWell Missouri Toolkit was developed to assist employers with reducing risk factors for chronic diseases, poor nutrition (including breastfeeding support), inactivity, stress, and tobacco use. The Toolkit is designed to help organizations assess and improve workplace wellness policies and practices. MOCAN members and partners will continue to promote the toolkit and partner with other organizations assisting businesses in the state to improve employee health.

Similar to the "Breastfeeding Friendly Worksite Award," the "Breastfeeding Friendly Child Care" award recognizes child care facilities who meet advanced criteria on the topic of breastfeeding support. Criteria include having a written policy that reflects support of breastfeeding; providing a welcoming environment for breastfeeding families; offering breastfeeding resources to parents; feeding infants on demand and communicating with families about feeding preferences; and training staff to support breastfeeding parents. Collaboration will continue with the Missouri Breastfeeding Coalition and local breastfeeding coalitions to promote the Breastfeeding Friendly Child Care Program.

Partnering with Child Care Aware, the "Breastfeeding Friendly Child Care" award and corresponding online training will be promoted, and those who meet the criteria to earn the award distinction will be publicly recognized. Plans to further promote the award to parents as well as providers will continue to be implemented. The DHSS, DESE and MOCAN will ensure the "Breastfeeding Friendly Worksite" and the "Breastfeeding Friendly Child Care" awards are highlighted during all worksite wellness outreach efforts. The Breastfeeding Program will also roll out the new "Breastfeeding Welcome Here" initiative to recognize businesses that agree to train staff to be welcoming to breastfeeding families and to display a "Breastfeeding Welcome Here" sticker on a door or window. This initiative will require little effort on the part of businesses and will help expand community support for breastfeeding by encouraging businesses that may not have a large number of breastfeeding employees to participate and receive breastfeeding support.

The CCHC Program will continue to provide training for child care providers to promote child care facilities as "Breastfeeding Friendly Child Care Facilities" for parents of enrolled children who are breastfeeding and as "Breastfeeding Friendly Worksites" for employees who are breastfeeding. LPHAs will utilize the CCHC program as

a partner in promoting the awards, as well as an important source of training. Both in person and online trainings will be available for this program to meet high provider demand. Both of these award programs are low cost, efficient, and provide realistic means to sustain support for breastfeeding families.

Resources for Parents

The Bureau of Genetics and Healthy Childhood (BGHC) Newborn Health Program participates in statewide educational activities that increase awareness and promote recommended and evidence-based MCH practices, including breastfeeding. The Newborn Health Program also provides, free of charge, Missouri's prenatal and newborn health book, *Pregnancy and Beyond*, and other educational literature to raise awareness and educate Missourians on the importance of breastfeeding and direct the public to resources to assist with breastfeeding. In addition to print materials, the Newborn Health Program maintains websites that provide electronic access to similar breastfeeding information/resources. The program will track the distribution of these materials and obtain feedback from its partners on how the materials are used and ways to improve the materials.

The Title V MCH funded Home Visiting Programs contracted home visitors will provide education, resources, and support to enrolled prenatal participants to promote breastfeeding initiation and sustained duration. Annual performance measure data will be collected on the percent of infants who were breastfed any amount at 6 months of age among mothers who enrolled in home visiting prenatally. The Home Visiting Program will assess home visitors' breastfeeding technical assistance needs through monthly subrecipient monitoring and provide resources and training opportunities through ongoing communication. Collaboration with the State Breastfeeding Coordinator and the Home Visiting Program will continue to assure up-to-date information, training opportunities, and support for all contracted home visitors.

Other Title V Program Activities Related to the Perinatal-Infant Health Domain

Risk-appropriate Care

The OWH will continue to implement provisions of Senate Bill 50 (SB50). SB50 requires Missouri birthing facilities to report their levels of maternal and neonatal care to the DHSS every three years. The OWH will implement provisions of the legislation by surveying birthing facilities through the CDC's Levels of Care Assessment Tool (LOCATe). LOCATe will help identify which facilities have no formal written transfer plan for high-risk deliveries. The OWH will collaborate with the Missouri Hospital Association (MHA) to assist identified facilities with incorporating a formal written transfer plan for high-risk patients. Having a written formal transfer plan in all facilities will ensure a more standardized approach for caring for these high-risk patients. This activity will also increase the likelihood of high-risk, very low birthweight babies being born at a level III+ facility, therefore reducing infant morbidity and mortality. SB 50 also requires all birthing facilities to have their levels of care verified every three years by either the American Academy of Pediatrics (AAP), The Joint Commission, or the DHSS.

Count the Kicks

In FY18, the Newborn Health program partnered with Healthy Birth Day, Inc. to implement and operate a Count the Kicks Public Awareness Campaign program to support pregnant women in Missouri and reduce Missouri stillbirth rates. According to the CDC, Missouri has the 18th highest stillbirth rate in the country. Missouri vital statistics show that there are approximately 353 stillborn births each year. The continued use of Count the Kicks in Missouri has the potential to save 91 babies every year if Missouri's stillbirth rate decreases by 26 percent, as has happened in neighboring Iowa where the campaign began. Count the Kicks teaches the method and importance of counting a baby's kicks in the third trimester of pregnancy. Free educational materials can be ordered from Count the Kicks at <https://www.countthekicks.org/order-materials/>. The Newborn Health program will continue to partner with a wide range of community health partners to promote the Count the Kicks program.

Newborn Screening

The Newborn Screening Program will continue to work towards increasing awareness of newborn screening with the goal of ensuring all newborns have access to newborn screening shortly after birth, thereby reducing the risk of mortality/morbidity related to undiagnosed and untreated metabolic, genetic, and endocrine disorders. Missouri law requires all babies born in the state to be screened for over 70 different disorders, including hearing loss and critical congenital heart disease. The Program will continue to work with the Missouri Midwives Association and the Amish and Mennonite communities to provide education and technical assistance when needed.

The Newborn Hearing Screening Program (NHSP) will continue to work towards ensuring newborns are screened by 1 month of age, diagnosed by 3 months of age, and enrolled in early intervention (EI) by 6 months of age. The NHSP will continue to pursue a reduction in loss to follow-up/loss to documentation to ensure newborns do not miss the opportunity to develop adequate language skills. Activities will include family support, referrals to EI, and education of health professionals and service providers.

Oral Health

Through continued collaboration with the Missouri Primary Care Association (MPCA) to provide education to women about the importance of dental visits during pregnancy, the Office of Dental Health (ODH) will continue to educate mothers about the importance of oral health for their overall health and well-being. ODH will also continue a pilot program with LPHAs to provide oral health education, fluoride varnish and a warm hand off to a dental clinic for pregnant women. The LPHAs will emphasize the importance of a dental visit during pregnancy and track the number of pregnant women who keep the appointment.

Neonatal Abstinence Syndrome (NAS)

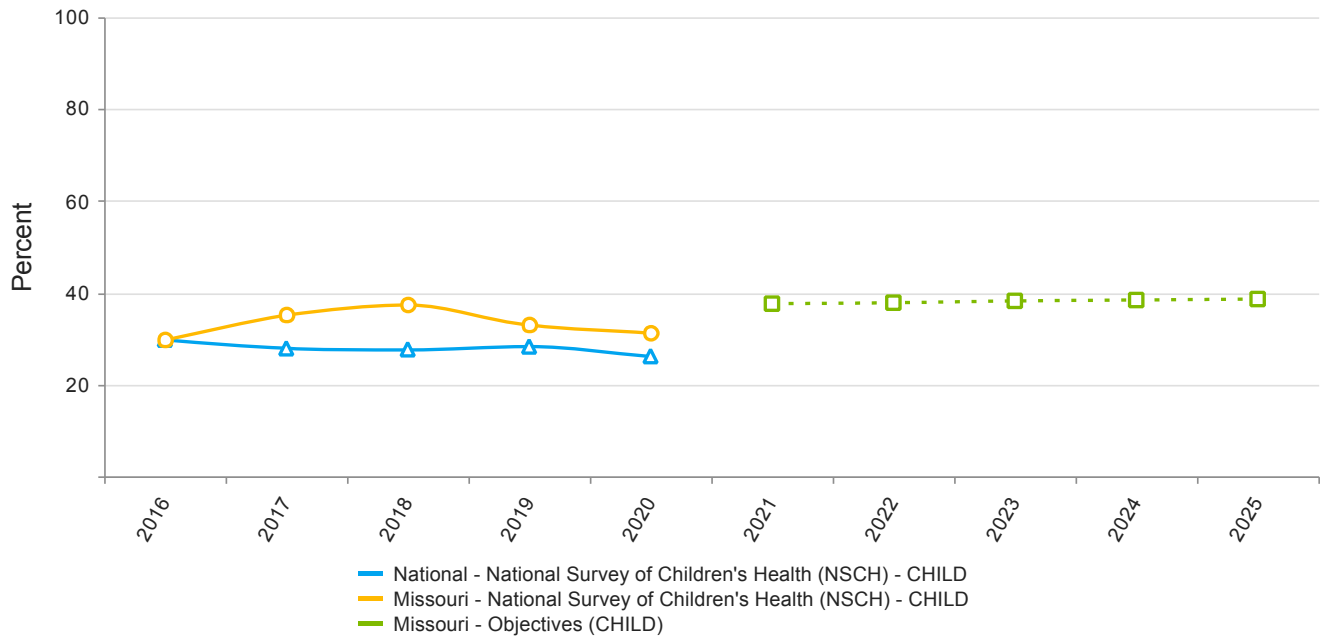
Through participation in the Association of State and Territorial Health Officials (ASTHO) and the Association of Maternal and Child Health Programs (AMCHP) Promoting Innovation in State & Territorial MCH Policymaking (PRISM) Learning Community, the DHSS leveraged Missouri's existing maternal-fetal-infant/neonatal abstinence syndrome (MFI/NAS) workgroups, including the NAS Stakeholder Workgroup previously facilitated by the DHSS, and contracted with the University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to organize, convene and facilitate a statewide Maternal Multisector Action Network (the Network). Focused on a life course framework, the Network will promote a coordinated, multidisciplinary system of care for women of childbearing age and pregnant and parenting mothers and advance policy proposals to: 1) address the impact of maternal substance use and mental health issues on the mother-infant dyad, and 2) assure health equity, racial/social justice, and a comprehensive continuum of care, including prevention and treatment efforts, for women/mothers with mental health and substance use disorders (SUD) and their families. The Network will use a landscape scan of State Policy Options for Perinatal Women with Substance Use Disorders provided by AMCHP to inform its priorities, goals, strategies, and future policy initiatives and will address risk and protective factors that influence health disparities within families and communities through the Life Course Perspective. A diverse, multisector and representative group of MCH, public health, mental health, behavioral health, SUD treatment, social services, and community partners and stakeholders, including local public health agencies, will be invited to participate in Network efforts. To incorporate the lived experiences of mothers of infants and young children affected by substance use and mental health challenges, the Network will promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities. The UMKC-IHD will conduct focus groups or "mapping sessions" to better understand the facilitators and barriers to accessing high quality and equitable services for mothers affected by substance use and mental health disorders. The UMKC-IHD will recruit two groups of individuals for focus groups: Mothers of infants and young children affected by substance use throughout the state of Missouri and service providers or individuals who work at organizations/agencies that provide support/services to mothers of young children affected by substance use

and mental health disorders. Understanding the lived experiences of mothers with substance use and mental health disorders and front-line clinical and social service professionals who work with women with substance use and mental health disorders before, during and/or after pregnancy will help guide the development of future services and support systems available to address maternal substance use and mental health, resulting in improved health outcomes for mothers and their children.

Child Health

National Performance Measures

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day Indicators and Annual Objectives



Federally Available Data

Data Source: National Survey of Children's Health (NSCH) - CHILD

	2019	2020	2021
Annual Objective			37.6
Annual Indicator	37.4	32.8	31.2
Numerator	174,971	156,884	145,507
Denominator	467,457	477,809	465,671
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

State Provided Data			
	2019	2020	2021
Annual Objective			37.6
Annual Indicator	32.8	31.2	31.2
Numerator	156,884	145,507	145,507
Denominator	477,809	465,671	465,671
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	37.8	38.2	38.4	38.6

Evidence-Based or –Informed Strategy Measures

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator	33	33	352
Numerator			
Denominator			
Data Source	MO DHSS Go NAPSACC data	MO DHSS Go NAPSACC data	MOPHIRS Report -CLPHS Service Log
Data Source Year	2019	2019	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	100.0	200.0	300.0	400.0

State Performance Measures

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Measure Status:					Active
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	73	71.5	71.7	71.9	72.1
Annual Indicator	70.4	70.9	74.2	72.5	72.5
Numerator	909,454	923,366	955,152	928,942	928,942
Denominator	1,291,860	1,302,509	1,288,116	1,280,625	1,280,625
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	72.3	72.5	72.7	72.9

State Action Plan Table

State Action Plan Table (Missouri) - Child Health - Entry 1

Priority Need

Reduce obesity among children and adolescents.

NPM

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Objectives

By 2025, Increase the percent of children, ages 6 through 11, who are physically active at least 60 minutes per day in the past week from 37.4% (NSCH 2017-2018).

Strategies

Implement community-based initiatives to promote and support healthy eating and active living.

Support activities and facilitate partnerships to create environments that support healthy eating and active living.

Encourage local health department staff to participate in school wellness committees at school districts within their jurisdiction.

Increase school-community collaborations to promote health.

Collaborate with DESE and other stakeholders to support schools to align with the Whole School, Whole Child, Whole Community model.

Support school districts in implementation of comprehensive school physical activity programs.

Build program and policy evaluation capacity.

ESMs

Status

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Active

NOMs

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

State Action Plan Table (Missouri) - Child Health - Entry 2

Priority Need

Enhance access to oral health care services for children.

SPM

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Objectives

By 2025, Increase the percent of children, ages 1 through 17, who had a preventive dental visit in the past year from 70.9% (NSCH 2017-2018).

Strategies

Establish collaborative relationships between non-oral health professionals and oral health professionals to strengthen the focus on oral health in the medical home and to ensure coordinated care.

Develop and distribute oral health educational information and materials geared toward the public and health professionals.

Provide oral health education at community-based settings.

Promote the delivery of preventive oral health care for children and adolescents by oral health professionals in school-based programs.

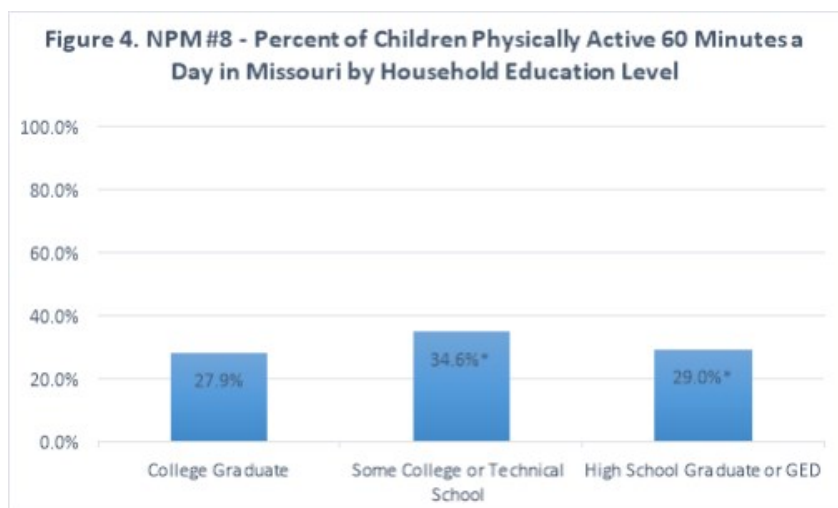
Build program and policy evaluation capacity.

Child Health-Annual Report

NPM #8 Physical Activity – Reduce obesity among children and adolescents.

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

According to the 2019-2020 National Survey of Children's Health (NSCH) data, 31.2% of Missouri children ages 6-11 years were physically active for at least 60 minutes a day, compared to their national counterparts (26.2%). Girls (33.4%) more commonly met this benchmark for physical activity than boys (29.2%). Survey findings suggest lower physical activity levels for children from college graduate or higher households (Figure 4). Children with public insurance only (32.2%*) were more frequently physically active for an hour daily than their national counterparts (27.5%).



Obesity is complex, and environmental and behavioral factors play a critical role. Healthy eating and regular physical activity are critical to achieving and maintaining good health. Missouri works to implement best practices to ensure all Missourians live in communities that support these healthy habits. Research by the Robert Wood Johnson Foundation (RWJF) forecasted Missouri would spend \$12 billion a year on obesity-related health care in 2030 as a result of alarming increases in childhood obesity. RWJF has previously ranked Missouri 17th in the nation for adult obesity. The 2020 Behavioral Risk Factor Surveillance System (BRFSS) reports more than two of every three adults are overweight (35.4%) or obese (34.0%). Some degree of adult obesity is likely reflective of poor dietary habits and sedentary behaviors formed in childhood that persist into adulthood. With that in mind, it is critical to support healthy habits early. About 80% of Missouri school districts provided data through the Department of Elementary and Secondary Education (DESE)/Department of Health and Senior Services (DHSS) data system collaborative. Of those students represented, 9% had asthma and had medication at home or school for the 2020-2021 school year. Additionally, there was an increasing proportion of students with Type 2 diabetes. Obesity and chronic condition prevalence rates are significantly higher among African American and Hispanic communities, which compounds the gap in health equity and educational attainment for children from these minority groups.

Obesity is a complex issue with many solutions, requiring collaboration from multiple organizations. One way

Missouri brings these partners together is through the Missouri Council for Activity and Nutrition (MOCAN), the statewide obesity prevention council facilitated by University of Missouri Extension (UME). MOCAN's member organizations are structured into workgroups specific to settings or topics: schools & child care, physical activity, worksites, food systems, and healthcare. DHSS staff supported through MCH funding participated in MOCAN workgroups to support statewide improvements in physical activity.

Policy and Environmental Changes

Developing a healthier community involves creating a culture that supports physical activity and provides access to safe places to be active. Policy and an appropriate environment are essential in supporting opportunities for children, youth, and families to develop healthy physical activity practices. In FY21, program staff in the Bureau of Community Health and Wellness (BCHW) continued to contract with local public health agencies (LPHAs) to implement policy and environmental changes that increase opportunities for children to engage in physical activity across multiple settings.

Child Care Wellness contracts were issued to six LPHAs to support training and technical assistance of child care providers to improve child care physical activity, nutrition policies, and practices. LPHAs used the University of North Carolina's Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) online system to assist child care providers with creating practices, policies, and environments that instill habits that support lifelong health and well-being and track child care providers' progress. However, due to the demands of pandemic response, LPHAs were unable to complete the Go NAPSACC modules with child care providers.

The DHSS, through BCHW and the Child Care Health Consultation (CCHC) Program, continued to support childcare providers with implementing policies and practices supportive of physical activity. Training, resources and technical assistance related to physical activity policies and practices were provided to child care providers who wanted to become a Missouri MOve Smart Child Care. MOve Smart recognizes child care programs that adopt policies and practices that support children's physical activity. Five child care programs received MOve Smart recognition in FY21.

The CCHC Program provided 123.5 hours of training and consultation to child care providers on the: recommended guidelines for physical activity and nutrition, implications of a healthy weight on overall health, and the role of breastfeeding in child nutrition and obesity prevention. The program also provided 164.75 hours of health promotion to children in child care on the topics of physical activity and nutrition. Health promotion increased children's knowledge on the importance of being active and provided examples of activities and games that promote physical activity, visual and hands-on demonstrations of healthy snacks and drinks, and resources and materials to share with their families about physical activity and nutrition. CCHC Program services increased access to information about physical activity and nutrition guidelines for children and families, and promoted involvement in community-based activities. CCHC Program services continued to be inclusive of adults and children of all abilities, encourage family participation in program services, optimize the health of children in child care, and provide resources and opportunities for collaboration with community-based organizations that promote physical activity and nutrition for children. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the ongoing COVID-19 pandemic.

BCHW contracted with Missourian's for Responsible Transportation to lead and conduct the Missouri Livable Streets Advisory Committee. This group consists of active transportation experts and advocates who collaborate to assist communities with improving accessibility of non-motorized transportation for all users throughout the state. The committee identified a statewide active transportation plan, outlining a vision and framework for improving accessibility, safety and affordability of active transportation, particularly for the most vulnerable populations, as a priority for their efforts. Such a plan will also identify and help prioritize strategies intended to increase multimodal

connectivity throughout the state. The committee is seeking collaboration with the Missouri Department of Transportation to assess the active transportation elements of surrounding states in order to evaluate how the plans were created.

Professional Development, Training, and Resources

BCHW staff also provide training and technical assistance on obesity prevention strategies to local communities. To ensure staff are well informed and can provide quality assistance, they participated in professional development opportunities such as annual conferences and other evidence-based training.

BCHW continued to support Missouri communities in their obesity prevention efforts by providing professional development and training opportunities for key stakeholders. Training opportunities included the virtual “*More Than Child’s Play, Leading Joyful and Purposeful Physical Activities with Young Children*” presented by Diane Craft, a national expert in preschool movement programs. Over 300 child care providers participated. Professional development opportunities were also made available to GO NAPSACC participants through the University of North Carolina’s online training. Additionally, technical assistance and resources were available to assist efforts to increase regular physical activity and healthful eating. BCHW’s MOve Smart website included physical activity training, providing one hour of continuing education for child care providers. In FY21, 288 child care providers completed the MOve Smart training. Child care providers could also access other materials to support physical activity on this webpage, including physical activity cards and videos for use in the classroom.

The School Health Program (SHP) supported school nurses to engage with students and families in addressing overweight/obesity in children. The SHP sponsored education and professional development in best practices (e.g., Lead Nurse Collaborative Meeting and ECHO webinar series for school nurses), collaborated with stakeholders and organizational partners to make tools and resources available to school nurses, and facilitated connections between students and families, schools, and communities.

Partnerships

BCHW staff participated in a number of coalitions and partnerships to help advance progress towards the state’s goals and objectives. Staff were involved in: MOCAN, Missouri Convergence Partnership, Missouri Coordinated School Health Coalition, DESE Missouri Healthy Schools Leadership Team, and the Missouri Complete Streets Advisory Committee. Staff had the opportunity to network and identify collaborative opportunities with other organizations working on similar goals, share available DHSS resources, and leverage funding to increase the reach of their work. For example, staff participation in the MOCAN Child Care Work Group strategic planning process led to alignment of the group’s goals with DHSS goals.

The MCH Services Program continued to contract with the 18 LPHAs that selected promoting physical activity and reducing and preventing overweight/obesity as their Priority Health Issue. LPHA efforts to prevent and reduce overweight/obesity and increase physical activity among children and adolescents included:

- Clay County Health Department increased the number of childcare centers that reviewed and updated policies for incorporating physical activity into daily classroom curriculum; thus increasing children’s level of daily physical activity. They also increased knowledge among children and their families on the importance of physical activity and nutrition; thus leading to a behavior change of incorporating these lifestyle changes into their daily routine.
- Henry County Public Health Center increased parent’s knowledge on the importance of youth getting a minimum of 60 minutes of daily physical activity; thus directly contributing to an increase in children and families adopting increased physical activity. A community swim event and a bubble walk were held with over 100 children in attendance. A new park, developed to be inclusive for children with disabilities, successfully

created opportunities for increased physical activity.

- Jefferson County Health Department worked to increase community education campaigns that increase daily physical activity for youth. A Spring into Wellness Program was implemented in 2021. 31 children age 12 and under signed up and individually logged at least 1,000 minutes/month of physical activity. 18 of those 31 children also had a parent or sibling participate. In addition, the health department partnered with local libraries and created Make and Take activity bags- these included a game that involved some type of physical activity. Lastly, the JeffCo Wellness Walk Project was implemented in collaboration with the parks department. Trail signs, with various physical activity and mental health activities and linked QR codes, were developed and placed on public trails, walkways, and paths.
- Randolph County Health Department worked to increase the number of health care providers who encourage daily physical activity for children ages 6-12. Specifically, they worked with the Moberly Regional Medical Center (MRMC) to implement the 12345 FitTastic! framework and consistent messaging component, and MRMC providers continue to use this framework in their practices. In addition, the health department increased the number of children ages 6-12 participating in daily physical activity by increasing exposure to healthy lifestyle education. For instance, the health department organized the Randolph County Summer Marathon. Participants were encouraged to complete 26.2 miles of physical activity throughout the summer months. 41 children were involved.
- Pulaski County Health Department increased the number of child- and adolescent-focused physical activities. The Adolescents Committed to Improvement via Exercise (A.C.T.I.V.E) program, implemented by four after school programs, collectively impacted over 100 children and adolescents who were trained to complete a 5K. In addition, the health department facilitated an AquaCize class in the summer months for women of childbearing age and children. The class was held at the local pool and encouraged children and families to be active.

SPM #1 Oral Health – Enhance access to health care services for children.

According to NSCH 2019-2020 data, nationally 77.5% of children ages 1-17 years old had a preventive dental visit in the past year. This was a greater percentage than in Missouri (72.5%). A lower percentage of Missouri children ages 1-5 years old (49.6%) had a preventive dental visit than their national counterparts (57.9%). This age group also had a lower percentage than Missouri children ages 6-11 years old (82.2%) and 12-17 years old (81.7%). Children who most frequently had a preventive dental visit in the past year were in college educated households (80.5%) followed by some college or technical school (68.7%), and high school graduate or GED (65.0%) households. Children with private insurance only (77.8%) more frequently had a preventive dental visit than publicly insured only (66.9%) and uninsured (45.2%*) children. Children in two-parent married households (73.6%) reported having more frequent preventive dental visit in the past year than single parent households (70.7%).

The Office of Dental Health (ODH) enjoyed continued success with the PSP, an evidence-based fluoride varnish and oral health education program. Pre-COVID, PSP served about 90,000 children each year; in FY21, 19,608 children participated in the traditional PSP. Each child received an oral health screening by a dental professional, two doses of fluoride varnish, oral health literature and supplies, and oral health education from school staff and volunteer dental professionals. Educational materials were provided by the ODH (for K-12 grade), but some schools choose to use their own materials. Due to the pandemic, many schools did not allow visitors to enter their school building. For those schools, PSP adapted and created 'Plan B PSP'. Plan B PSP provided grade-specific and narrated educational videos for teachers to show their classes. A Zoom call could also be scheduled with the school's ODH Oral Health Consultant if they did not have their own educational materials or training. Oral health supplies and literature were provided and fluoride varnish was either applied by a trained school staff member or sent home for parents or guardians to apply to their child's teeth. 8,598 children participated in Plan B PSP. The ODH's Oral Health Consultants were also

available to school nurses to advise regarding potential dental health needs. School nurses could take pictures of a child's teeth if there was a questionable issue, and an Oral Health Consultant helped determine the need for dental care. The ODH Program Manager presented a webinar to 78 school nurses in April 2021 on the importance of oral health and promoted the PSP. This was the second-most attended webinar offered by the School Nurse Program and given high reviews. The webinar was recorded for nurses who missed the presentation. In July 2021, an ODH Oral Health Consultant presented a webinar during the Orientation for School Nurses, an orientation for new school nurses and a refresher for established school nurses. The webinar was viewed by 258 individuals.

The ODH continued to promote the use of dental sealants as an effective means to prevent decay on newly erupted molars and is actively seeking new partnerships to provide dental sealants in school-based clinics. The ODH continued to work with two LPHAs and two dental health clinics to apply sealants in their clinics and at local schools.

The ODH's Five-Year State Oral Health Plan was finalized and disseminated and is still a subject of ongoing communication with partners.

The ODH continued its efforts to:

- Increase access to dental care by providing education about the importance of maintaining the adult dental benefit among MO HealthNet recipients. Information is distributed to policymakers, dental providers, leaders, and oral health stakeholders via the DHSS website and partners like the Missouri Coalition for Oral Health and Missouri Dental Association;
- Contract with the Missouri Primary Care Association (MPCA) to provide education and technical assistance to State Dental Directors from all FQHCs in Missouri. The MPCA also assists the ODH with distributing educational materials regarding the importance of a dental health home for everyone, particularly for pregnant women and children;
- Support the development of the oral health workforce in Missouri through collaborations with the DHSS Office of Rural Health and Primary Care on incentive programs for dental professionals; and
- Implement the "referrals" portion of the PSP, linking children with an identified dental need to local dental providers and coordinated through school nurses and other local champions.

Strategies to enhance access to oral health care services for children also included providing education to public, city officials, dental and medical professionals, and public health authorities about the safety and effectiveness of community water fluoridation for the prevention of dental caries. The ODH also continued to improve the Missouri Oral Health Surveillance System to include updated fact sheets on topics of interest and regional reports compiling oral health statistics and related information. The ODH created a Tableau dashboard with data from our PSP program to break oral health data down by area or county and provide a visual representation of the data. The data can be found on our Missouri Oral Health Data page located at [Oral Health Data | Oral Health | Health & Senior Services \(mo.gov\)](#).

Partnerships

Much of Missouri is a dental health provider shortage area, meaning many Missourians are neither located close to a dentist nor do they have a dental home. COMTREA (a Federally Qualified Health Center (FQHC)) assists parents in understanding the importance of oral health and linking children with dental care to address barriers to dental services such as transportation, ability of parents to miss work, ability to pay, and knowledge of services available. The ODH worked with COMTREA to provide assistance and support as needed in the form of educational materials and handouts.

ODH also partnered with Level Up, a dental program in Kansas City that helps to meet the oral health care needs of low-income children in Clay and Platte Counties. The program has two full-time dentists who provide treatment on-

site in schools (with a mobile unit) and at other social service organizations. All dental services are free for children who meet income guidelines. The ODH provided over 1,000 tubes of toothpaste for children seen through this program.

In Missouri, there are approximately 14,000 children in foster care through the Department of Social Services (DSS)—Children’s Division (CD) at any given time. CD has 46 circuits that work with these children, their families, and their foster/kinship placements. These children are part of an underserved population that is facing significant health disparities, including low socioeconomic status and limited access to medical professionals and services. Children brought into state custody are enrolled in Medicaid, a system often lacking the dental professionals needed to ensure equitable access to oral health care. Additionally, in many cases, these children live in areas experiencing dental professional shortages. Combined with barriers to access created by the pandemic, many children were either unable to access oral health care or had their dental appointments canceled and then had to wait months to get them rescheduled. As part of an intra-departmental collaboration between the DHSS–ODH and DSS–CD, foster children were supplied a packet of oral health materials to help improve their oral health and decrease the oral health disparity. Each packet included two applications of fluoride varnish, two tubes of toothpaste, a toothbrush, and two pieces of educational material: *Dental Sealant* and *Baby Teeth Are Important* card. Additionally, virtual education was provided in the form of fluoride varnish application training for all the CD staff. The ODH Oral Health educational video series for children (for K-12 grade) was made available for them to learn more about the importance of oral health. These materials were shipped to the CD central office and then distributed to each of the 46 circuits. From there, Children’s Service Social Workers took packets to each child during their monthly home visits. The central office distributed the virtual educational materials along with a short letter of explanation about the packets via their foster/kinship placement listserv, and included the links to the fluoride varnish training and the oral health educational video series. During the monthly home visit, the Children’s social worker gave the packet to the foster/kinship placement caregivers and reminded them about the email that was sent with the educational information. The foster/kinship placement caregivers utilized the oral health items to apply fluoride varnish and repeat the application 3-6 months later as needed, depending on the child’s oral health need. Additionally, the children utilized the toothbrushes and toothpaste regularly. The ODH office received telephone calls from the foster/kinship placement caregivers reporting the packets were a wonderful surprise and would help improve the children’s oral health, and the children were excited to receive the items. The caseworkers expressed their thanks for the opportunity to help families and acknowledged how much it would benefit the children. Overall, this project enabled children to receive some type of oral health preventive service.

The SHP coordinated with the ODH and other programs to provide evidence-based information, resources, and professional development to school nurses supporting them with best practices to educate children and parents about oral health concerns as well as promote the need for annual dental visits and regular preventative practices in oral health. This was accomplished by offering a virtual presentation, to all 106 new school nurses, about the ODH and the programs they offer. An additional virtual meeting was scheduled for all lead school nurses about the ODH and oral health resources available.

The TEL-LINK Program referred 142 callers to dental clinics to increase awareness of community resources to access needed dental health services. The program provided outreach to the underserved population through effective marketing strategies. The marketing strategies included relevant search terms and ads using an online search campaign. When individuals Google key search words such as: “dental clinic near me”, “dental care”, or “help with dental expenses”, the results provide a click-to-call (mobile only) ad, allowing customers to call TEL-LINK with a single click. Providing this type of effective marketing strategy has increased dental referrals. Before these campaigns, the average referral would be less than 14 calls per year for dental care.

The Missouri WIC Program procured infant and toddler toothbrushes to make them available in local WIC clinics.

Literature was available to LPHAs, dental offices, and community outreach events such as health fairs. The importance of regular dental care was also communicated through promotion of the use of dental sealants. Referrals and care coordination components of the Preventive Services Program (PSP), described in more detail below, also encouraged regular dental visits for children, particularly those identified with a dental/oral health need.

The CCHC Program provided 10 hours of training and 20 hours of consultation services to child care providers on the importance of oral health, oral health guidelines, and the implications of oral health on overall health. As a result of CCHC consultations and trainings, child care providers demonstrated increased knowledge and awareness of the implication of a child's oral health on their overall health, and learned strategies they could implement at their child care facility to promote oral health. CCHC trainings also increased child care provider knowledge related to identifying abnormal oral health conditions in infants and young children, oral care and specific implications for Children with Special Healthcare Needs (CSHCN), and overcoming challenges and barriers to providing oral care for CSHCN. The CCHC Program also provided 60.25 hours of health promotion to children in child care on the importance of oral health. As a result, these children were able to verbalize why their teeth are important, what could happen if they do not care for their teeth, and identify unhealthy snacks and beverages that could harm their teeth. These children also participated in visual and hands-on demonstrations of proper tooth brushing and flossing techniques and were provided with educational materials, toothbrushes, and toothpaste to enhance both their excitement surrounding oral care and ability to participate in oral care at home. These educational materials also increase parental awareness on the importance and recommended frequency of preventative dental checkups. CCHC services continued to be inclusive of adults and children of all abilities, encourage family involvement in program services, and provide referrals to outside community resources for children's oral health services when applicable. CCHC services continued to optimize the overall health of children in child care. The capacity for LPHAs to deliver CCHC Program services was severely impacted by the ongoing pandemic.

The Title V/MCH and the Maternal, Infant and Early Childhood Home Visiting (MIECHV) funded home visiting services, managed under DESE-OOC, are offered in 26 counties and served 1,008 families in FY21 through four evidence-based home visiting models:

- Nurse Family Partnership;
- Healthy Families America;
- Parents as Teachers; and
- Early Head Start Home Based Option.

Home Visiting promoted National Children's Dental Health Month, which is observed annually in February, to all MCH and MIECHV funded home visitors through the Home Visiting Program's second quarter continuous quality improvement newsletter, *Quality Outlook*, and in the Weekly Updates on January 15, 2021 and February 5, 2021. Ordering information for oral health resources from the ODH and the MPCA were emailed to all MCH and MIECHV funded home visitors and supervisors, as well as links to materials, webinars, and other resources that highlight the importance of preventive annual dental care for children. The resources were shared ahead of the virtual Title V/MCH and MIECHV specific home visiting summit held on March 10, 2021. Additionally, a presentation on oral sealants was presented by an oral health Public Health Program Specialist during the virtual Title V/MCH and MIECHV specific home visiting summit. Sealant kits from the ODH were mailed to all locally contracted home visiting implementing agencies for distribution to their enrolled families following the presentation. The presentation included the following resources: [Oral Health and The Lemony Lion](#) video and a varnish application demonstration available at the following [link](#).

Other Title V Program Activities Related to the Child Health Domain

The Missouri WIC program continued to offer training and support to local agencies and community partners interested in implementing the WIC Developmental Milestones Program. 76 out of 115 local agencies have implemented the WIC Developmental Milestones Program. The early years of a child's life are very important for his or her health and development. Missouri parents, health care providers, educators, and others can work together to help children grow up to reach their full potential. The WIC Developmental Milestones Program uses a set of age-appropriate developmental checklists starting at 2 months of age to 5 years based on the Centers for Disease Control and Prevention's (CDC) LTSAE materials to increase parents' awareness of developmental milestones and to promote the early identification of potential developmental delay. *"Talking is Teaching: Talk, Read, Sing"* is an expansion of the language component of the WIC Developmental Milestones Program. 18 out of 115 local agencies have implemented this initiative. *"Talking is Teaching: Teaching: Talk, Read, Sing"* helped parents recognize their ability to improve their children's early brain and vocabulary development. Efforts by the WIC program to recruit non-participating local agencies and external partners to implement the WIC Developmental Milestones Program continued. Five agencies were recruited in FY21. Training and support was provided to local agencies interested in implementing the program, including the language component. Implementation training developed by the CDC was used to onboard new local agencies enrolling in the program. Resources for *"Talking is Teaching: Talk, Read, Sing"* and Developmental Milestones, were available through the online order form, and warehouse literature orders were distributed to WIC local agencies. The CDC Amazing Me books were available in English and Spanish for children 1 – 5 years of age.

The DHSS supported participating entities by providing education and promotional items, including printed materials such as the developmental checklists and the Amazing Me books developed by the CDC. These resources were available for WIC agencies as well as internal and external stakeholders as part of providing educational support and promotion of early identification of potential developmental delays. Monthly updates on various child development topics were posted on the Missouri WIC webpage to provide education and support to local agencies. Wichealth.org developed five lessons to educate parents on Developmental Milestones for infants and children at different ages. Local agencies enrolled in the Developmental Milestones program can utilize these lessons to help enhance parent's understanding of how to use CDC's milestone checklists. Along with tips and activities to support healthy development, these lessons highlight the important role nutrition plays in achieving their child's milestones. Local agencies can refer their participants to these lessons for two out of four required nutrition education contacts within a certification period.

WIC Agencies were required to complete the Association of Public Health Nutritionist (ASPHN) "Introduction to Child Development" training for WIC staff. The Missouri WIC Facebook page hosted monthly posts to promote the program to local agencies and the public. Results from a FY21 local agency survey were used to determine current program participation rates, clinic activities, and training needs from participating agencies, as well as gather data on program interest from agencies not currently enrolled. Feedback from agencies not currently enrolled in the program will be used to design future promotional activities. Three out of 16 (18.75%) non-participating agencies reported interests in implementing the program in FY22. Information was collected on activities the agencies utilized before and during the pandemic to screen for developmental delays. One agency stated, "The same parents who want the nutrition counseling and have questions are the ones who enjoy the milestone program the most." From the survey, the need was identified to reintroduce the 'Introduction of Child Development Training.' This training provides counseling staff information on child development in the first 1000 days and then next 1000 days (2 to 5 years of age).

The SHP surveyed all school nurses to evaluate the effectiveness of resources developed for school health personnel. Information from the CDC was identified as the most useful resource, along with: the DHSS/DESE School Reopening and Operating Guidance; online communication from the School Health Program with timely updates/ announcements; LPHA direct communication, information, and partnerships; and the DHSS/ DESE

COVID-19 Webinars for Schools and LPHAs. Direct communication, information and the partnerships developed with LPHAs were also appreciated. Additionally, respondents found a number of individuals very helpful in providing COVID-related information for the school, including the District Lead School Nurse, the State School Nurse Consultant, their District Administrator, and LPHA staff.

Increased stress levels was an almost universal theme, with 92.8% of respondents indicating that their stress levels increased during the 2020-2021 school year compared to before the pandemic, and stress continued to increase into the 2021-22 school year. Many school nurses reported working longer days than in the past and the inability to complete many “routine” school nurse duties, primarily providing health education, oral health and hearing screenings, and follow-up related to health screenings.

The survey also identified positive outcomes from the pandemic, such as: developing new partnerships with LPHAs, the District COVID-19 Team and District Administrators; being given the authority to implement new communicable disease guidelines; and the opportunity to assume new roles, e.g., school spokesperson, contact tracer, and decision-maker for school policies. Survey feedback also included a wide spectrum of emotional responses to the pandemic. While some indicated this was an experience to grow from, and that positive aspects were present, the majority indicated feeling anxious, concerned, discouraged, dissatisfied, drained, frustrated, helpless, overwhelmed, or stressed.

*Please interpret with caution. The width of the 95% confidence interval exceeds 20 percentage points or 1.2 times the percent value. As a result, the percentage may not be reliable.

NPM #8 Physical Activity – Reduce obesity among children and adolescents.

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

Policy and Environmental Changes

Developing a healthier community involves creating a culture that promotes the benefits of physical activity and allows access to safe places to be active. Public policy is essential in supporting opportunities for children, youth, and families to develop healthy physical activity practices. Strategies to promote policy and environmental changes that can foster healthier communities in which opportunities and safe places to be physically active abound include collaboration with internal partners, local public health agencies (LPHAs), youth, and statewide and community organizations with similar goals. Program staff in the Bureau of Community Health and Wellness (BCHW) will continue to contract with three LPHAs to implement policy and environmental changes that increase opportunities for children to engage in physical activity in early care and education settings.

The LPHAs will use the University of North Carolina's Nutrition and Physical Activity Self-Assessment for Child Care (Go NAPSACC) online system to assist child care providers to improve the health of young children through practices, policies, and environments that instill habits supporting lifelong health and well-being and track child care providers' progress. The Child Care Health Consultation (CCHC) Program Manager will continue to assist LPHA staff that provide Go NAPSACC technical assistance and consultation to child care providers as part of the program's nutrition and physical activity consultations.

Through BCHW and the Community Food and Nutrition Assistance program, the Department of Health and Senior Services (DHSS) will continue supporting child care providers to implement policies and practices supportive of physical activity. This is to occur by providing training, resources and technical assistance related to PA policies and practices to child care providers in their effort to become a Missouri MOve Smart Child Care.

The CCHC Program at the Department of Elementary and Secondary Education (DESE) will provide consultation hours for child care providers to support the implementation of policies and procedures that support physical activity. These consultation hours may include recommended guidelines for physical activity and nutrition, policies and procedures that promote indoor and outdoor physical activity, addressing barriers for indoor and outdoor activity, implementing screen time policies, and consultation and training on becoming a Missouri MOve Smart Child Care designated facility.

Professional Development, Training, and Resources

BCHW staff are also available to provide training and technical assistance on obesity prevention strategies for local communities. To ensure staff are well-informed and can provide quality assistance, they plan to participate in professional development opportunities such as annual conferences of professional associations and other evidence-based training.

BCHW will continue to support Missouri communities in their obesity prevention efforts by providing professional development and training opportunities for key stakeholders. Additionally, technical assistance and resources are available to assist efforts in increasing regular physical activity and healthful eating. BCHW will also assist communities in assuring interventions are inclusive of individuals of all abilities.

The School Health Program (SHP) will continue to encourage school nurses to engage with students and families in addressing overweight/obesity in children. SHP will sponsor education and professional development in best-practices (e.g., Lead Nurse Collaborative Meeting and ECHO webinar series for school nurses), collaborating with stakeholders and organizational partners to make tools and resources available to school nurses, and facilitating connections between students and their families, schools, and communities.

The CCHC Program will continue to provide trainings for child care providers and health promotion for children in their care on the importance of physical activity. Trainings for child care providers will focus on physical activity and its positive effects on weight, physical and mental health, and the development of motor, social/emotional, and cognitive skills. Trainings will also address how to incorporate structured and free active play into daily routines, address AAP guidelines for screen time, and provide examples of age appropriate activities and games to promote physical activity. In June 2022, 25 CCHC Program trainers completed Nemours Physical Activity Learning Session (PALS) 'train the trainer' sessions, and are now equipped to provide physical activity trainings for child care providers in their respective counties. Trainings and health promotions will incorporate the 12345 Fit-Tastic! Healthy Lifestyles Initiative messaging and guidelines developed by the Weighing In organization funded by Children's Mercy Hospital, which incorporate guidelines for nutrition and physical activity for children in easy to utilize messages and materials. Health promotions for children in child care will also provide fun and developmentally appropriate opportunities for physical activity, increase children's knowledge on how physical activity keeps their minds and heart healthy, and enable children's involvement in fun activities, songs, books, and games that promote physical activity and structured and unstructured play. CCHC Program services will continue to provide evidence-based resources and educational materials for child care providers and the parents/guardians of children in child care, provide resources and opportunities for collaboration with community-based organizations that promote physical activity and nutrition for children, and encourage family participation in all program services.

Partnerships

BCHW staff participate in a number of coalitions and partnerships that help to advance progress towards the state's goals and objectives. Examples of groups in which staff are involved include: Missouri Council for Activity and Nutrition (MOCAN), Missouri Convergence Partnership, Missouri Coordinated School Health Coalition, DESE Healthy Schools Project, and the Missouri Livable Streets Advisory Council. Staff have the opportunity to: network and identify collaborative opportunities with other organizations working towards similar goals, share available DHSS resources, and leverage funding to increase the reach of their work. Through the MOCAN Schools Workgroup, BCHW staff are working to promote use of the Whole School Whole Community Whole Child framework in Missouri schools. The workgroup will share resources to assist schools in this effort. An additional goal of the group is to strengthen district wellness policies and practices that promote healthier school environments.

Through the Missouri Healthy Weight Advisory Committee, BCHW staff support work to increase the capacity of the health care workforce to provide evidence-based family-based treatment programs for children that are overweight and obese. Health care providers (RD/LCSW/etc.) will be surveyed to identify existing capacity to provide family based obesity therapy. In 2022, the state's Medicaid program made it possible for providers to bill for obesity treatment for pediatric patients. The surveys will also identify where additional resources are needed to increase health care provider capacity to provide these services. The ultimate goal will be to establish a training and certification program to increase the providers available to provide these services.

The MCH Services Program will continue to contract with the 23 LPHAs that selected promoting physical activity and reducing and preventing overweight/obesity as the Priority Health Issue being addressed in their FY 2022-2026 MCH Services contract work plan. LPHA efforts to prevent and reduce overweight/obesity and increase physical activity among children and adolescents will include:

- Knox County Health Department plans to work with their County Ball Association and school districts to implement healthy food options in their concession stands using the *Eat Smart in Parks* toolkit. The nutrition guidelines in the toolkit help set a standard for the foods and drinks offered in parks and contain measures that can help boost the availability of healthy food choices. The health department has replaced sugary beverages with options with less sugar and plans to do a “sampling” of some healthier options to survey community members on which foods they would like to see added as concession options.
- Mercer County Health Department plans to use the *Water Access in Schools* Toolkit from the Centers for Disease Control and Prevention (CDC) to implement a water access plan within schools to increase availability of free safe drinking water in gyms and other physical activity areas. They also plan to work with the Russ Derry Sports Complex to update playground equipment so that it is not only safe but also inclusive for all children.
- Scotland County Health Department plans to work with the City of Memphis and implement safe drinking water filling stations in parks and recreational sites to encourage children and adolescents to drink more water when being active. They will also educate providers (child care, medical, grocers, library, etc.) on the 12345 Fit-Tastic! Healthy Lifestyles Initiative and provide messaging materials as requested (bookmarks, handouts, posters).
- Cooper County Health Department plans to work with at least two schools that have before or after school programs and incorporate physical activity opportunities for children by using GoNoodle, Brain Gym, and 12345 Fit-Tastic! messaging. In collaboration with school health staff/PE teachers, they also plan to host an annual Walk to School Day in October.
- Benton County Health Department plans to develop a community resource guide that identifies walking trails, parks, swimming pools/public beaches, bowling alley, skate park, YMCA, and other opportunities for physical activity among children and adolescents. They will provide nutritional education classes for children and families to teach them how to read nutrition labels, wash produce, and prepare a healthy recipe.

SPM #1 Oral Health – Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Ordering information for oral health resources from the Office of Dental Health (ODH) and the Missouri Primary Care Association (MPCA) will be provided to all MCH funded home visitors to promote National Children’s Dental Health Month, which is observed annually in February. National Children’s Dental Health Month will also be highlighted in the Home Visiting Program’s continuous quality improvement newsletter, *Quality Outlook*, and the *Weekly Update* emailed to all MCH funded home visitors and supervisors to provide links to materials, webinars, and other resources that highlight the importance of preventive annual dental care in children. The Missouri WIC Program will collaborate with ODH to procure infant and toddler toothbrushes to have them available in their local WIC clinics.

Additionally, literature is available to LPHAs, dental offices, and community outreach events such as health fairs. The importance of regular dental care is also stated within the context of the ODH’s promotion of the use of dental sealants. The referrals and care coordination components of the Preventive Services Program (PSP), described in more detail below, also encourage regular dental visits for children, particularly those who have been identified as having an oral health need.

The ODH enjoys continued success with the PSP, which is an evidence-based fluoride varnish and oral health education program. PSP serves about 90,000 children each year. Each child receives an oral health screening by a dental professional, two doses of fluoride varnish, oral health literature and supplies, and oral health education. The oral health education is either provided by school staff or the dental professionals that volunteer to operate PSP. Educational

materials are provided by the ODH (for each grade, K-12), but some schools choose to use their own materials. During the Coronavirus pandemic, many schools were not allowing visitors to enter their school building. Those restrictions have been lifted for most schools. For the schools without the restrictions, PSP will continue as it was implemented pre-COVID. Oral health supplies and literature will be provided, and fluoride varnish will either be applied by a trained school staff member or sent home for parents or guardians to apply to their child's teeth. ODH's Oral Health Consultants will also be available to school nurses to advise on possible dental health needs. School nurses can take pictures of a child's teeth if there is a questionable issue, and an Oral Health Consultant will help in determining the need for dental care.

The SHP will continue to coordinate with ODH and other programs to provide evidence-based information, resources, and professional development to school nurses supporting them with best practices to educate children and parents about oral health concerns as well as promote the need for annual dental visits and regular preventative practices in oral health. The SHP will continue to host the ODH during the statewide meeting of lead school nurses in an effort to recruit additional schools to offer school-based oral health programs. The SHP will offer a 60-minute orientation for all new school nurses on oral health programs and the role of the oral health consultant.

The ODH will continue to promote the use of dental sealants as an effective means of preventing decay on newly erupted molars and is actively seeking new partnerships to provide dental sealants in school-based clinics. In addition to using MCH funding to work with two LPHAs and a dental health clinic to apply sealants in their clinics and at local schools, the ODH will leverage other grant funding to work with eleven LPHAs to apply fluoride varnish to the teeth of their high-risk children, mainly through their WIC programs.

Through an agreement with the DESE, the ODH will continue to provide free oral health screenings, fluoride varnish and oral care supplies to children at the Missouri Schools for the Severely Disabled. Registered Dental Hygienists will provide screenings, alert the school nurses when the child has an urgent issue that needs immediate attention, and provide fluoride varnish, which has been shown to decrease the amount of dental decay with two or more annual applications.

The TEL-LINK Program will refer callers to dental clinics to increase awareness of community resources to access needed dental health services. The program will continue to provide outreach to the underserved population through effective marketing strategies.

The CCHC Program at the DESE will continue to provide consultation and training for child care providers and health promotion for children in child care on the importance of oral health, oral health promotion, and the impact of oral health on physical health. Consultations will ensure that the child care facility has evidence based policies and procedures that promote optimal oral health for children and assist with their implementation. Trainings will increase the child care provider's knowledge on oral health guidelines and promotion strategies, abnormal oral conditions in infants and young children, and specific implications for oral care for CSHCN. Health promotion for children in child care will provide developmentally appropriate and fun oral health education and help children understand why it's important to take care of their teeth, identify unhealthy snacks and beverages that could harm their teeth, and participate in hands on demonstrations of proper tooth brushing and flossing techniques. CCHC Program services will continue to provide child care providers and children in child care and their families with educational materials, toothbrushes, toothpaste, and floss to enhance their excitement surrounding oral care and ability to participate in oral care at home. These educational materials will also increase parent/guardian awareness on the importance and recommended frequency of preventative dental checkups. CCHC services will continue to be inclusive of adults and children of all abilities, encourage family involvement in program services, and provide referrals to outside community resources for children's oral health services when applicable.

The MCH Services Program will support LPHA efforts to:

- Provide education on the importance of adequate dental care and overall oral health;
- Collaborate with partners to provide screening, referral and direct provision of preventive dental services; and
- Increase the number of children, ages 1 to 17 years of age, receiving a preventive dental visit in the last year.

The MCH Services Program will continue to contract with the seven LPHAs that selected enhancing access to oral health care services for children as the Priority Health Issue for their FY 2022-2026 MCH Services contract work plan.

- Audrain County Health Department will collaborate with the WIC program to provide oral health screening and referral for WIC participants interested in the Fluoride Varnish program. A health department nurse will apply fluoride varnish and provide oral health education and a warm handoff to the Arthur Center for follow-up dental care.
- Wright County Health Department will collaborate with the WIC program to provide oral health screening, apply fluoride varnish, and provide oral health education for children. The health department has created oral health kits that include a toothbrush, floss and toothpaste and will give the kits to all children ages 1-17 who visit the health department.

Additional strategies will include providing education to the public, city officials, dental and medical professionals, and public health authorities about the safety and effectiveness of community water fluoridation for the prevention of dental caries. The ODH will also continue to improve the Missouri Oral Health Surveillance System to include updated fact sheets on topics of interest and regional reports compiling oral health statistics and related information.

The ODH will leverage other grant funding to contract with two dental clinics and one dental hygiene school to bring a dentist and dental hygienists to provide teledentistry services to schools. These services will target counties with very few or no dentists and provide dental services to children who may not otherwise have access to oral health services.

The ODH will continue to disseminate and engage partners in ongoing discussion related to the Five-Year State Oral Health Plan and continue its efforts to:

- Increase access to dental care by providing education about the importance of maintaining the adult dental benefit among MO HealthNet recipients. Information is distributed to policymakers, dental providers, leaders, and oral health stakeholders via the DHSS website and partners like the Missouri Coalition for Oral Health and Missouri Dental Association;
- Contract with the MPCA to provide education and technical assistance to State Dental Directors from all FQHCs in Missouri. The MPCA assists ODH with distributing educational materials regarding the importance of a Dental Health Home for everyone, particularly for pregnant women and children;
- Support the development of the oral health workforce in Missouri through collaborations with the DHSS Office of Rural Health and Primary Care on incentive programs for dental professionals; and
- Implement the “referrals” portion of PSP, linking children with an identified dental need to local dental providers. This will be coordinated through school nurses and other local champions.

Other Title V Program Activities Related to the Child Health Domain

Developmental Screening

The CCHC Program will continue to provide consultations and trainings for child care providers around health and safety topics, including social-emotional learning, language/communication, cognitive, and movement/physical development in children. Consultations and trainings for child care providers will focus on incorporating the use of:

developmental monitoring tools and checklists, strategies that positively affect child development, and individualized health plans (IHPs) for children with developmental delays. Trainings for child care providers will include the CDC “Learn the Signs. Act Early.” (LTSAE) campaign materials with the updated developmental milestones checklists. Trainings will stress the importance of monitoring developmental milestones, and provide communication strategies that child care providers can use when communicating with parents/guardians regarding concerns with a child’s development. Health promotion lesson plans for children in child care will continue to support all domains of child development. CCHC Program services will continue to provide resources about child development and developmental monitoring and screening provided for child care providers and parents/guardians of children in child care. Parent/guardian participation in all program services will continue to be encouraged.

Inclusion Specialists will provide parents with listings of child care providers, based on the geographical location requested by the parent, so that parents can choose child care that will meet the needs of their child. Enrolling a child in a program that is prepared to meet the needs of that child will increase the likelihood of maintaining placement, which will support the educational needs of the child. Inclusion Specialists provide onsite consultation to assist child care providers and develop adaptations and strategies to include the child with special needs in everyday classroom activities. They will assist in setting achievable goals for the child’s ongoing development. Inclusion Specialists deliver group training to better increase the knowledge base of child care providers in Missouri on how to include children with special needs. Lastly, through the addition of a social-emotional learning project, specialists also deliver research-based training to child care professionals to help them understand how children develop socially and emotionally, as well as research-based intervention strategies on how they can foster social-emotional development in real, practical ways.

The Home Visiting Program’s contracted home visitors will use the Ages and Stages Questionnaire®- 3 (ASQ-3) screening tool to identify children’s developmental needs. Home visitors will provide referrals for children who score below the cut-off points indicating a need for: additional developmental assessment, information and activities, community support, or early intervention services through Missouri First Steps or Early Childhood Special Education to contribute to improved school readiness. Annual performance measure data will be collected on the percentage of ASQ-3 developmental screenings conducted at the specified time points of 9, 18, and 30 months of age. Annual performance measure data will also be collected on the percentage of completed referrals for children who score below the cut-off points of the ASQ-3.

Additionally, the Home Visiting Program’s contracted home visitors will continue best practices to screen all children of enrolled participants, birth to kindergarten entry, for social-emotional development using the Ages and Stages Questionnaire®: Social Emotional (ASQ:SE-2). Home Visitors will provide developmental activities for parents/children who score in the “monitoring” range and will assist families in accessing services as appropriate.

The Home Visiting Program will provide all contracted home visitors with education on childhood mental health conditions and warning signs through a variety of communications including postings within the Missouri Home Visiting Gateway resources and weekly updates, located on the Home Visiting Program’s web-based data collection system platform, and during annual professional development events.

The Newborn Health Program will partner with a wide variety of community health providers to distribute the *Pregnancy and Beyond* booklet as well as other educational materials that provide information on developmental screening. The program will track the distribution of these materials and obtain feedback from its partners on how the materials are being used and ways to improve them.

The Missouri WIC Program will continue to promote the public awareness campaign “*Talking is Teaching: Talk, Read, Sing*” to help parents recognize their ability to improve their children’s early brain and vocabulary development. Training will be provided statewide to WIC agencies, home visitors, Head Start, Parents as Teachers, health care providers, library staff, and other community partners. Handouts created to give caregivers tips on fun

and easy ways to improve their child's learning and books developed by the CDC as part of the LTSAE public health campaign will be distributed to stakeholders to share with families as part of their educational efforts.

The Missouri WIC program will also continue to offer training and support to local agencies and community partners interested in implementing the WIC Developmental Milestones Program. (*See NPM #11 - Medical Home application narrative for additional details.*)

The DESE Office of Childhood is developing an early childhood system that is family friendly and ensures every young child receives services needed. The work undertaken by this new Office includes the development of an Early Childhood Integrated Data System, the development of a virtual resource database for all families with children ages 0-5, and the development of community leaders across the state. This work builds off work of the Early Childhood Comprehensive System (ECCS) that was led by DHSS for several years. A new grant, "ECCS Health Integration: Prenatal to 3 Program," in the amount of \$255,600 per year for each of the next 5 years, was awarded to Missouri in August 2021. This funding will support the ECCS Program in leading the first integration of health needs, resources, and systems into the existing Statewide Early Care and Education (ECE) Strategic Plan and will build on current collaborative efforts to increase the impact for the prenatal to three population.

The MCH Services Program will support LPHA efforts to:

- Provide infant and early childhood developmental and social-emotional screening services;
- Provide developmental screening for children one to three years of age enrolled in LPHA home visiting programs;
- Participate in preschool and pre-Kindergarten screening;
- Provide direct school-health services, including developmental screening; and
- Refer infants and children with potential developmental delay or failure to meet expected developmental milestones.

The Childhood Lead Poisoning Prevention Program (CLPPP) will support Title V strategies by actively providing information about the potential harmful cognitive and developmental effects that may occur following a child's blood lead level elevations. Information will be provided to:

- The general public;
- Health care providers, such as obstetricians;
- LPHA and health plan lead clinical case managers;
- WIC staff;
- Foster care placement families;
- Asthma Program participants;
- Newborn Home Visiting Program families;
- DESE staff, including school nurses, Parents As Teachers (PAT), Head Start, and Early Intervention/First Steps staff and
- Parents of children with elevated blood lead levels.

CLPPP will provide information about:

- Substances and environments that are likely to be lead exposure sources;
- The need for and ways to avoid/remove/prevent a child's exposure to environments or substances with lead;
- The need for blood lead testing for children under the age of 6 years per current CDC and American Academy of Pediatrics recommendations;
- Medicaid testing requirements;
- The recommended environmental and clinical follow up of children with elevated blood lead levels; and

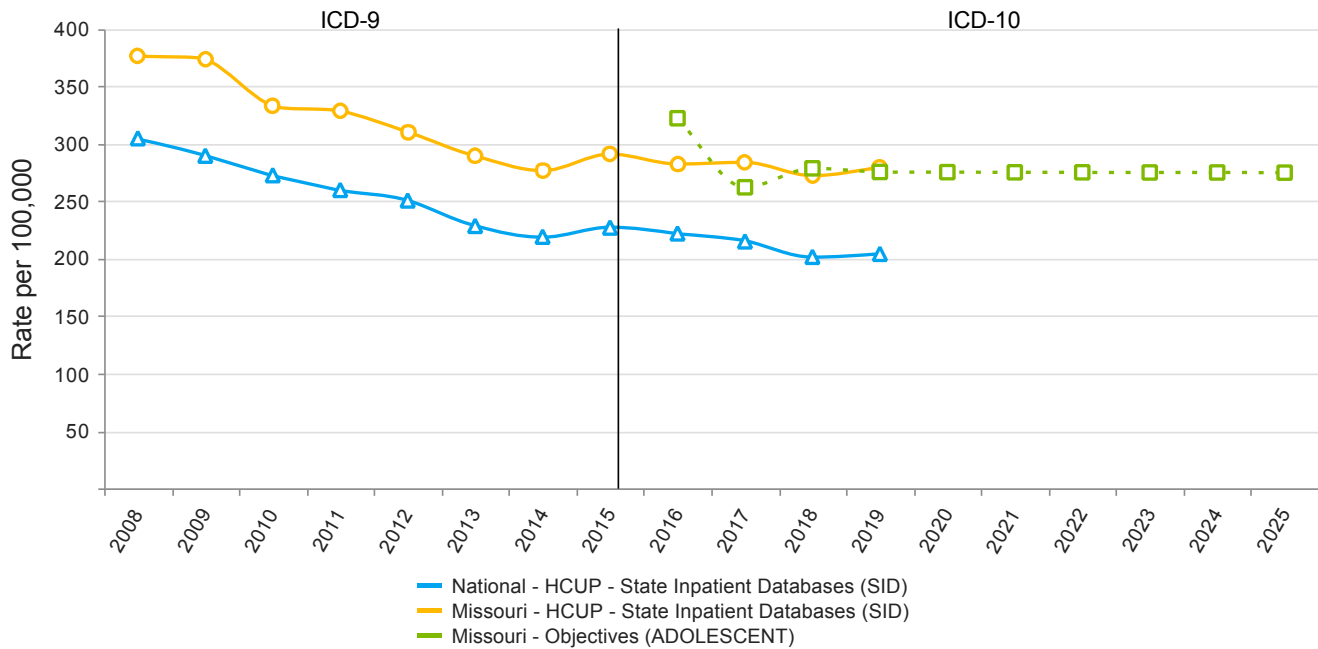
- The recommended tracking of blood lead testing; and
- Extended developmental monitoring of children with elevated blood lead levels.

Missouri will continue to support and improve coordinated systems of care to address the needs of maternal, infant, and child populations that are at risk for or experience exposure to lead. There is a strong partnership between Missouri's Title V Program and the CLPPP activities, which enhances the impact that the programs can make.

Adolescent Health

National Performance Measures

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19
Indicators and Annual Objectives



Note: ICD-10-CM beginning in 2016; previously ICD-9-CM with 2015 representing January - September

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	2018	2019	2020	2021
Annual Objective	262	278.4	275.2	275.1	275
Annual Indicator	291.9	281.6	284.0	271.9	278.6
Numerator	1,718	2,211	2,226	2,130	2,175
Denominator	588,524	785,023	783,928	783,327	780,786
Data Source	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	262	278.4	275.2	275.1	275
Annual Indicator	275.3	250.2	254.1	275.9	275.9
Numerator	2,158	1,960	1,984	2,148	2,148
Denominator	783,928	783,327	780,786	778,428	778,428
Data Source	MO PAS	MO PAS	MO PAS	MO PAS	MO PAS
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	274.9	274.8	274.8	274.7

Evidence-Based or –Informed Strategy Measures

ESM 7.2.1 - Percentage of high school students who reported distracted driving.

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			45
Annual Indicator	45.8	45.8	45.8
Numerator	722	722	722
Denominator	1,576	1,576	1,576
Data Source	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	44.2	43.5	42.5	41.5

State Performance Measures

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			17.4
Annual Indicator	17.4		17.4
Numerator	1,200		1,200
Denominator	6,897		6,897
Data Source	YRBS		YRBS
Data Source Year	2019		2019
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	16.8	16.2	15.5	15.0

State Action Plan Table

State Action Plan Table (Missouri) - Adolescent Health - Entry 1

Priority Need

Reduce intentional and unintentional injuries among children and adolescents.

NPM

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Objectives

By 2025, decrease the rate of hospital admissions for non-fatal injury among adolescents, ages 10 through 19 from 250.2 per 100,000 (PAS 2018).

Strategies

Ensure health care providers have access to tools and best practices regarding injury prevention and are trained to use the tools in an evidence-based manner.

Ensure high quality injury prevention counseling is embedded in programs for which Title V has authority.

Educate partners regarding evidence-based policy and environmental strategies that prevent or reduce injury rates among children and adolescents, and the relative effectiveness of these policies and strategies.

Educate partners regarding existing community resources for referrals or collaboration to support injury reduction and promote injury prevention.

Build program and policy evaluation capacity.

ESMs

Status

ESM 7.2.1 - Percentage of high school students who reported distracted driving.

Active

NOMs

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

State Action Plan Table (Missouri) - Adolescent Health - Entry 2

Priority Need

Promote Protective Factors for Youth and Families.

SPM

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Objectives

By 2025, reduce the suicide death rate among youth 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics).

Strategies

Create supportive environments that promote connectedness and healthy and empowered individuals, families, and communities.

Foster positive public dialogue, counter shame, prejudice, and silence; and build public support for suicide prevention and mental health promotion.

Address the needs of vulnerable groups, tailoring strategies to match the cultural and situational contexts in which they are offered, and seek to eliminate disparities.

Coordinate and integrate existing efforts addressing adolescent health and behavioral health to ensure continuity of care.

Promote changes in systems, policies, and environments that will support and facilitate the prevention of suicide and related problems.

Collaborate with behavioral health agencies/partners to implement the Strengthening Families Protective Factors Framework.

Promote efforts to reduce access to lethal means among individuals with identified suicide risks.

Apply the most up-to-date knowledge base for suicide prevention.

Implement and spread evidence-based suicide and self-harm prevention strategies and programs.

Strengthen collaboration across agencies, develop new tools and capacity, and implement evidence-based change in suicide and self-harm prevention strategies.

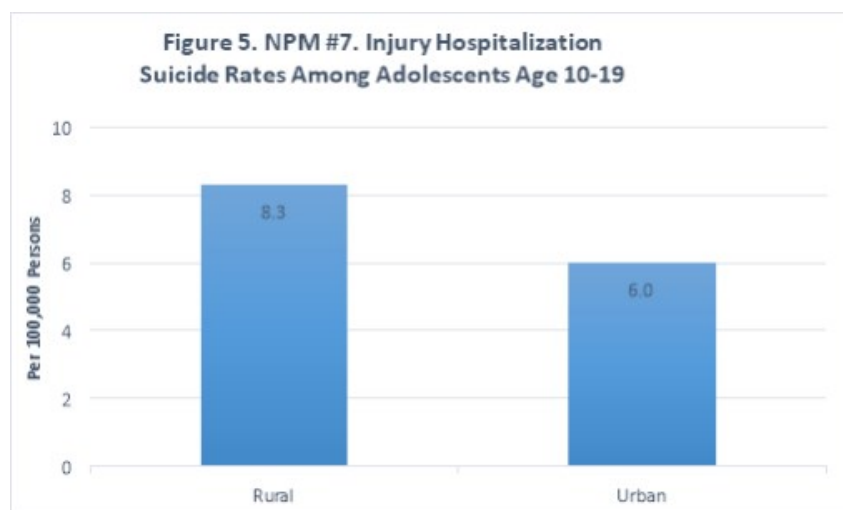
Implement and spread evidence-based prevention and emergency mental health programs.

Build program and policy evaluation capacity.

NPM #7 Injury Hospitalization – Reduce intentional and unintentional injuries among children and adolescents.

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

Among Missouri adolescents 10 to 19 years old, the rate of non-fatal injury hospitalizations was 275.9 per 100,000 in 2020 compared to 254.1 per 100,000 in 2019. The top three causes of injury deaths among Missourians ages 10 to 19 years old in 2020 were: 1) motor vehicle accidents, 2) homicide, and 3) suicide. Motor vehicle accidents was the number one cause of unintentional injury deaths in this age group followed by accidental poisoning and exposure to noxious substances. Suicide remains a public health issue of great significance in Missouri. For 2020, the overall rate of suicide in Missouri for all ages was 18.3 per 100,000 compared to 13.9 per 100,000 for the US. According to 2020 Missouri Vital Statistics data, suicide was the eleventh cause of death for all ages and the third cause of death among adolescents 10-19 years old. Additionally, the suicide rate among adolescents aged 10-19 of 6.8 per 100,000 was slightly higher but quite comparable to the national rate of 6.7 per 100,000. Suicide rates indicate higher risk in rural areas (Figure 5), (presenting challenges for the provision of mental health services as rural counties typically have fewer mental health resources available than urban counties. Multiple prevention strategies in Missouri were implemented to address unintentional and intentional injuries.



The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide and provided funding for 10 Safe Kids Coalitions. The coalitions reached 59 counties to provide unintentional injury prevention services to children aged 0-19 years. The coalitions were led by a variety of agencies including local public health agencies (LPHAs), non-profit entities, and local hospital systems. The coalitions worked to increase knowledge, attitudes, and skills to address priorities such as teen driver safety, sports safety, medication safety, fire safety, and water safety. The coalitions offered a broad array of activities and education, such as the National Safety Council's Defensive Driving Course (DDC), to increase parent and child awareness and knowledge on injury prevention priorities. Teens ages 14 and up were encouraged to take DDC and learn state and local traffic laws, distracted driving prevention, and safe driving practices. Additional injury prevention activities included hosting educational and prescription drug take back events, conducting media campaigns with prevention messages, and working with policy makers to address gaps in policies that could prevent injuries. The coalitions worked closely with law enforcement

officers, fire fighters and paramedics, medical professionals, educators, parents, businesses, public policy makers, and most importantly, adolescents, to reinforce teen driver safety. The coalitions provided services to over 1,500 children and parents through over 30 teen safety educational events. BCHW hosted the Safe Kids Missouri Leadership Workshop to promote workforce development. Coalition leaders and other partners received information on suicide prevention from the Department of Mental Health (DMH). The Department of Health and Senior Services (DHSS) presented on injury data, Safe Kids Worldwide, and the Consumer Product Safety Commission. The Injury Prevention Program continued to build program capacity and partner with current Safe Kids coalitions to provide programs, identify gaps in current services, and increase the number of partners supporting programs.

The Injury Prevention Program continued to strengthen collaboration with TEL-LINK and Text4baby to provide information and resources about car seats and seat belts. Family engagement continued to be a priority for Safe Kids coalitions. The coalitions continued to incorporate families into coalition activities, and the DHSS provided technical assistance to further that effort.

The Injury Prevention Program coordinated the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC). The MIVPAC provided advice, expertise, and guidance to the Missouri Injury Prevention Program and established injury prevention as a state priority. The committee consisted of representative members from state agencies, local and regional government agencies, non-government bodies, and consumers. The Committee's goal was to reduce the morbidity and mortality of children aged 0 -19 years due to injuries and violence. The Committee completed a strategic plan and began to implement strategies such as: maintaining an updated list of MIVPAC members; utilizing the MIVPAC website to highlight members; promoting upcoming injury prevention events; tracking opportunities for MIVPAC members to present on evidence-based injury and violence prevention strategies; tracking communication from MIVPAC leadership to members, partners, and consumers; and gathering intentional and unintentional injury information and data.

The MCH Services Program continued contracts with the 35 LPHAs that identified the reduction of intentional and unintentional injuries among adolescents as the Priority Health Issue to be addressed in their FFY 2019-2021 MCH work plans. The Program continued to support LPHA efforts to prevent and reduce injury related to:

- Fire and water safety;
 - The Camden County Health Department collaborated with the Missouri State Parks Department to supply life jackets to a loaner station at a local state park fishing and kayaking area, resulting in an increased number of children and adolescents wearing a life jacket to prevent drowning.
- Motor vehicle safety/accidents;
 - Webster County Health Department collaborated with the Webster County Department of Motor Vehicle (DMV) to address risk reduction related to motor vehicle accidents among adolescents. A policy was created within the Webster County DMV to provide motor vehicle and safe driving educational materials when teens present to obtain a permit or driver license. As a result of these efforts, the health department reported an increase in knowledge of the Missouri Graduated Driver License Law as well as the Buckle Up Phone Down message to deter distracted driving.
- Child abuse and neglect;
 - The Laclede County Health Department created a MCH taskforce, worked with local child and youth serving organizations to create child/adult policies to protect children, and provided the Darkness to Light Steward of Children child sexual abuse education. These activities resulted in increased knowledge regarding protecting children from sexual abuse among child and youth serving organizations and providers.
- Violence; and
 - The St. Louis County Health Department partnered with local schools to provide education, including a

trauma fact sheet, a community resource guide, violence prevention education and distribution of gun locks, to 900 students. In addition, the health department partnered with the Urban League to provide the same education to food distribution events with over 1800 attendees. This training resulted in increased knowledge regarding violence prevention among children and adolescents.

- Lead poisoning
 - The Johnson County Health Department partnered with local child care providers to implement a lead testing policy as part of enrollment. The Health Department also implemented an internal policy to integrate lead testing education with Temporary Medicaid enrollment. These policies resulted in an increased number of children being tested and screened for elevated blood lead levels (EBL).

Young Children Specific

The CCHC Program provided training and consultation to child care providers on numerous health and safety topics, many of which focused on injury prevention and reduction among children. Topics included; abuse and neglect, mandated reporting, behavioral health, emergency preparedness and disaster planning, CPR/First Aid, medication administration, poisoning prevention, fire safety, gun safety, injury prevention, motor vehicle safety, playground safety, safe sleep, stranger safety, water safety, and sun safety. Trainings and consultations increased access to information, resources, and optimal policies at child care facilities for injury prevention. The Program also provided health promotions to children in child care on similar safety topics with the addition of child-related behaviors such as biting and bullying. Health promotions provided children with meaningful experiences and resources regarding health and safety promotion and injury prevention that could be implemented in their lives outside the child care facility. The capacity for LPHAs to deliver CCHC services was significantly impacted by the ongoing COVID-19 pandemic.

Safe Kids coalitions addressed priorities including child passenger safety, bicycle safety, crib safety, TV and furniture tip-over, pedestrian safety, poisoning, farm safety and other safety topics based on community needs. The coalitions offered a broad array of activities, including: providing cribs and car seats with parental education, conducting car seat checks, providing certification training for child passenger safety technicians (CPST), conducting media campaigns with prevention messages, and working with policy makers to address gaps in policies that could prevent injuries. The coalitions provided services to over 30,000 children and parents through over 550 educational events. Over 1,900 child safety seats were distributed, and over 2,500 car seat checks were conducted.

The DHSS Injury Prevention Program Manager represented District 5 (Central District) on the MO Child Passenger Safety Advisory Committee. Responsibilities included maintaining regular contact with all CPSTs/inspection stations in the district, being available to sign off on seats for CPST/instructor recertification, mentoring new instructors, being the main point of contact when the Missouri Department of Transportation orders car seats for the area inspection stations, recruiting new inspection stations, and attending CPS Advisory Committee meetings. The MCH Director, Injury Prevention Program Manager, MCH Program Manager, and MCH District Nurse Consultants served on statewide and regional safety coalitions such as the Missouri Coalition for Roadway Safety state and regional coalitions and the Occupant Safety Subcommittee. The MCH Director participated on the Missouri Brain Injury Advisory Council, MIVPAC, and the MO Council for Adolescent and School Health (CASH).

The Childhood Lead Poisoning Prevention Program (CLPPP) continued to provide education and support to LPHAs, health care providers, and families of children under the age of six through identification of potential lead hazards and provision of information on hazard reduction and remediation. Building additional relationships with other child health and wellness focused agencies and entities to further support messaging on all child-related topics was a focus. CLPPP also continued to promote childhood blood lead screening and testing, and efforts led to 52,455 blood lead tests reported for children under six years of age. Postponement of care during the COVID-19 pandemic response negatively impacted routine blood lead screening and testing. In FFY-2021, three children were

reported to have undergone chelation therapy.

SPM #2 Suicide and Self-Harm – Promote Protective Factors for Youth and Families.

It is normal for children and adolescents to experience some emotional distress as they develop and mature. However, studies such as the Adverse Childhood Experiences (ACEs) show that the toxic stress and challenges young people face can have a significant impact on their long-term health. According to the 2019 Youth Risk Behavior Survey (YRBS), 33% of high school students in Missouri reported being sad or hopeless almost every day for two or more weeks in a row, causing them to stop doing some usual activities in the 12 months prior to the survey. According to the NSCH 2019-2020 data, 10.1% of Missouri children between 3-17 years received treatment or counseling from a mental health professional in the last 12 months compared to 11.0% nationally. Among children that were publicly insured only, 11.9% received treatment or counseling, which was slightly lower in comparison to 13.3% nationally. There were comparable percentages among children with private health insurance only, with 9.9% in Missouri and 9.8% nationally. Missouri college graduate households had a greater percentage of those who received treatment or counseling (12.5%) than any educational attainment group for which there is data at both the state and national levels. Some college or technical school households (12.1%) at the national level were the next highest in percentage among all education groups for Missouri and nationally. Among Non-Hispanic White children, 11.6% of Missouri children received treatment or counseling, which was slightly lower than the 12.2% of children nationally. For Missouri (8.2%) and nationwide (9.0%), there was a less than one-percentage point separation for those with two, currently married -parents. For Missouri (10.0%) and nationally (9.8%), children between 6-11 years were very similar regarding the proportion of children that received treatment or counseling. Among those that were 12-17 years old, a lower percentage of Missouri (14.6%) children received counseling or treatment than nationwide (15.7%). Partners across Missouri worked to improve protective factors, access to mental health treatment, and the quality of staff and support services working with youth who have experienced trauma and multiple ACES.

The DHSS continued to be a member of the Missouri Suicide Prevention Network (MSPN), which leads statewide suicide prevention efforts. MSPN's goal is to coordinate, develop and implement the Missouri Suicide Prevention Plan. MSPN members provided recommendations and advice to support MSPN's overall mission and work to eliminate the stigma of suicide, educate the community about suicide, and ultimately reduce the rate of suicide in Missouri.

The DHSS School Health Program (SHP) continued to partner with the DMH, Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), and other agencies and organizations to identify training and resources and facilitate connections with school districts across Missouri. The SHP supported professional development for local school health staff to implement trauma-informed approaches and best practice recommendations for creating safe spaces for all students, including LGBTQ and other at-risk students. After attending a one-hour presentation on trauma, four school districts requested district-wide consultations with the school health staff to address trauma. Through the Show Me School Based Health Alliance partnership, the SHP supported school-based clinics to provide services, including mental and behavioral health, on school campuses or near schools.

Inclusivity refers to the degree to which programs are sensitive toward, responsive to and encompassing of the diverse experiences and needs of all youth and families. The Adolescent Health Program (AHP) continued to disseminate training to contractors and partners to improve inclusivity across youth-serving organizations. The AHP also continued to provide Foundations trainings to school personnel across Missouri in order to help the districts evaluate and improve their health curriculums for inclusivity.

In conjunction with the Personal Responsibility and Education Program (PREP) and the Sexual Risk Avoidance

Education (SRAE) grants, the AHP continued to implement evidence-based teen pregnancy prevention and positive youth development programs across Missouri's highest need areas. The Teen Outreach Program (TOP), Becoming a Responsible Teen, Making Proud Choices, and Making a Difference programs continued to improve not only the knowledge of Missouri's youth, but also their self-efficacy, health outcomes, and school outcomes.

The AHP also continued to work towards having adolescent input at the state-level. The AHP began the process to implement youth advisory councils as part of the teen pregnancy prevention grant contracts, and each contractor will be required to have youth advisors or start a youth advisory council (YAC), and these youth will be part of a network the DHSS can reach out to for advice on issues facing youth. The AHP began training contractors on working with youth and will continue to work with contractors to grow skills related to developing YACs over the next few years.

The AHP continued to focus on Social-Emotional Learning (SEL) through the training and expansion of Teen Outreach Program (TOP) Clubs across Missouri. The AHP expanded SEL through continued Youth Thrive and SEL Institute trainings, which were started in FFY18 in conjunction with Wyman, Inc. These trainings are targeted to youth-serving organizations such as schools, LPHAs, DHSS contractors, and social service agencies. The trainings teach the basics of adolescent brain development and trauma-informed care and increase the SEL knowledge of adults who work directly with youth.

The AHP worked with Wyman, Inc. on a new program, Teen Connection Project (TCP), which focused on building communication skills, SEL, and developing connections between high school aged youth and their peers as well as adults. These protective factors meld well with achieving the goals of Missouri's Title V MCH State Action Plan. Wyman piloted this program, including a rigorous evaluation, in parts of Missouri and across the country. The AHP leveraged funding from the Missouri Foundation for Health to pilot TCP in rural high schools in Missouri for the 2021-2022 and 2022-2023 school years. AHP staff completed the facilitator and trainer-of-trainer trainings and began working with three rural sites.

The AHP also continued to leverage adolescent pregnancy prevention funds to work on adult/child relationships through the Connect with Me campaign. The campaign encouraged parents/guardians, teachers, coaches, and all adults to have stronger relationships and deeper conversations with the youth they care about. Topics included in the conversation starter cards included trauma, healthy body image, taking action, and others. The AHP worked to expand the campaign to include a phone app, which will expand outreach capabilities and increase the variety of topics available.

Missouri is part of Region VII of the National Network of State Adolescent Health Coordinators (NNSAHC), and the four SAHCs collaborate to share information and provide similar messaging and trainings. The NNSAHC is a resource to communicate ideas, build knowledge, and expertise. Missouri's State Adolescent Health Coordinator (SAHC) served as the NNSAHC Vice President. Missouri reached out to this network to gather ideas regarding addressing adolescent mental health and suicide prevention, and the idea for a toolkit was sparked.

The DHSS participated in the second cohort of the Children's Safety Network Child Safety Learning Collaborative (CSLC) to reduce fatal and serious injuries among infants, children, and adolescents. The CSLC concluded in October 2021. The CSLC strategy team included the MCH Director, the Injury Prevention Program Manager, the AHP Manager, and the Manager of Trauma-Informed Treatment at the DMH. The strategy team collaborated with stakeholders to improve Missouri's efforts to address suicide and self-harm and completed the *Navigating your Child's Mental Health Crisis* toolkit for Missouri families. Missouri's toolkit is adapted from the Society for the Prevention of Teen Suicide toolkit to make it more appropriate for use in the school setting and provides comprehensive guidance for families with youth experiencing a mental health crisis. The DHSS partnered with

stakeholders, such as LPHAs, the Missouri School Board Association (MSBA), and school nurses, working to address mental health to distribute the adapted toolkit to local school districts.

The MCH Services Program supported LPHA and/or community partner efforts to provide education, screening, and referral for adolescent mental health needs. The Program continued contracts with 15 LPHAs that identified the prevention and reduction of suicide and/or self-harm in their local adolescent populations as the Priority Health Issue to be addressed in their FFY 2019-2021 MCH work plans. These efforts included but were not limited to preventing substance use, preventing and reducing the impact of toxic stress, and building resiliency. Examples of LPHA contract outcomes included:

- Osage County Health Department provided tools and resources to support and strengthen current laws to prevent the sale of substances to minors by implementing a Junior Deputy Program as well as a *You Card, We Care* Program. The Junior Deputy Program promoted to be citizens that possess good moral character, integrity, trustworthiness, and the desire to perform good deeds for others. Each participant was given the opportunity to independently accomplish a specified goal with the guidance of experienced mentors. Each Junior Deputy will then become a mentor to the next class of Junior Deputies. The *You Card, We Care* Program recognized responsible servers and vendors in an effort to reduce youth access to harmful substances and contribute to a healthy community. The Health Department also increased accessibility to mental wellness services for students by providing one full-time counselor within the public school district in Linn.
- Camden County Health Department increased substance use and self-harming behavior awareness and education in the community by displaying two billboards with messages related to keeping substances safely locked up and/or discarded. In addition, they created a suicide prevention toolkit/bag that was distributed to each student who attended prom and graduation.
- Platte County Health Department increased the number of school systems with intervention crisis teams, specifically utilizing the Handle with Care System, resulting in increased knowledge, collaboration and support among community partners and the school district to ensure students have the emotional tools they need to be successful in school when experiencing trauma at home. In addition, the Roots of Resilience Action Guide (a 6-week, 12-hour virtual course with discussion and next steps for building resilience in youth) was shared with faith-based leaders, health department staff, and hospital leadership teams. 66 adults were trained to lead this program. Virtual Coffee Cafés were offered weekly for ages 8 and older to provide mental health trainings and resources. Youth Mental Health First Aid is designed to teach parents, family members, caregivers, teachers, school staff, peers, neighbors, health workers, and other caring citizens on how to help an adolescent (age 12-18) who is experiencing a mental health or addiction challenge or is in crisis. Youth Mental Health First Aid virtual trainings were provided, with 47 adults in attendance. Health Department efforts resulted in an increase in knowledge and resources shared.
- Dallas County Health Department increased the number of providers that offered and/or implemented evidence-based programs in suicide prevention. The Dallas County R-1 Schools partnered with County Memorial Hospital to provide on-site counseling to students within the district. In addition, school faculty and staff were trained with the Trauma-informed school curriculum, Adult and Youth Mental Health First Aid and QPR (Question, Persuade, and Refer). The most recent Missouri Student Survey data for Dallas County revealed that student thoughts of depression, sadness and suicide improved from the previous survey. The LPHA increased the number of community events that promoted suicide prevention, such as the Grow Healthy Buffalo 5K/Health Fair. The LPHA was also very active on social media, with a Facebook reach of 3300. The LPHA implemented #mentalhealthmatters, a social media campaign which involved Health Department staff posting mental wellness messages and resources to Facebook each Monday.
- Cass County Health Department increased the number of middle and high school students who received

Signs of Suicide (SOS) training. The training is now provided in two additional school districts and was used for in-person, hybrid and virtual classes throughout the COVID-19 pandemic.

In addition to the above activities, the Child Care Consultation (CCHC) Program provided training designed to help child care providers identify children with mental health needs and address mental illness prior to reaching adolescence.

Adolescent Health - Application Year

NPM #7 Injury Hospitalization – Reduce intentional and unintentional injuries among children and adolescents.

Please note that some of the strategies and activities listed below impact both the Child and Adolescent Health domains. To avoid duplication, the information will only be listed in this domain, for which it is anticipated to have a larger impact, but it should be noted that some strategies and activities may address a wider age range.

The Bureau of Community Health and Wellness (BCHW) serves as the state lead for Safe Kids Worldwide and provides funding for 10 Safe Kids Coalitions. The coalitions reach 60 counties to provide unintentional injury prevention services to children aged 0-19 years. The coalitions are led by a variety of agencies including local public health agencies (LPHAs), non-profit entities, and local hospital systems. The coalitions work to increase knowledge, attitudes, and skills to address priorities such as teen driver safety, sports safety, medication safety, fire safety, and water safety. The coalitions offer a broad array of activities and education, such as the National Safety Council's Defensive Driving Course (DDC), to increase parent and child awareness and knowledge on injury prevention priorities. Teens ages 14 and up are encouraged to take the DDC and learn state and local traffic laws, distracted driving prevention, and safe driving practices. Additional injury prevention activities include: participating in health and safety fairs, providing education through school and community events, hosting drug take back events, conducting media campaigns that incorporate prevention messages, and working with policymakers to address gaps in policies that could prevent injuries. The coalitions work closely with law enforcement officers, fire fighters and paramedics, medical professionals, educators, parents, businesses, community agencies, public policy makers, and, most importantly, adolescents, to reinforce teen driver safety. The Department of Health and Senior Services (DHSS) will host quarterly conference calls and offer a one-day workshop for all coalitions to gain knowledge of evidence-based interventions and network with other coalitions.

The Injury Prevention Program will continue to build program capacity and partner with Safe Kids coalitions to provide programs, identify gaps in current services, and increase the number of partners that could support programs. The Injury Prevention Program will continue to collaborate with TEL-LINK and Text4baby to provide information and resources about car seats and seat belts. Family engagement will also be a priority for Safe Kids coalitions, and families will continue to be incorporated into coalition activities. The DHSS will provide technical assistance to further that effort.

The Injury Prevention Program will continue to coordinate the Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), which provides advice, expertise, and guidance to the Missouri Injury Prevention Program, and to establish injury prevention as a state priority. The Committee consists of representative members from state agencies, local and regional government agencies, non-governmental bodies, and consumers. The Committee's goal is to reduce the morbidity and mortality of children aged 0 -19 years due to injuries and violence. MIVPAC will continue to focus efforts on implementing the strategic plan, including strategies to promote partnerships and collaborate with partners to improve injury prevention efforts in Missouri and to promote MIVPAC as the resource for best-practice recommendations to address injury and violence prevention.

The MCH Services Program will continue contracts with 23 LPHAs that identified the reduction of intentional and unintentional injuries among adolescents as the Priority Health Issue to be addressed in their FFY 2022-2026 MCH work plans. The Program will continue to support LPHA efforts to prevent and reduce injury related to:

- Fire and water safety;
 - The Hickory County Health Department is working with the Sea Tow Foundation's Life Jacket Loaner Program to implement life jacket loaner stations in state parks that have water access points. Those participating in water activities may borrow the life jackets at no cost and are asked to return them

when they are finished. Additionally, the Health Department plans to partner with the Summer Reading Program at the local library to provide water safety education to children and adolescents.

- The Camden County Health Department has established life jacket loaner stations within state parks that have water access points. The life jackets are intended to be borrowed, free of charge, for those participating in water activities, and returned when finished. The health department also partners with the Missouri State Highway Patrol- Water Patrol Division to provide water safety education to preschool and school-aged children and adolescents.
- Motor vehicle safety/accidents;
 - The Sullivan County Health Department will work with Think First Missouri to bring the *ThinkFirst for Teens School Assembly Program* to schools in the county. The Program will be offered free of charge and provide a high-impact injury prevention message from a speaker who has sustained a brain or spinal cord injury, usually due to a motor vehicle crash.
 - The Moniteau County Health Department will continue to provide education and safe driving resources to those who come to the health department to get a birth certificate for the purpose of obtaining a permit/driver license.
 - The Osage County Health Department will work with local schools to implement the [Buckle Buddy Program](#). The Program, sponsored by the Missouri Coalition for Roadway Safety, aims to teach children the importance of proper seatbelt and booster seat use and start them on the path toward lifelong seatbelt usage and includes a stuffed toy dragon, “Buddy”, a story and a song.
- Child abuse and neglect;
 - The MCH Services Program, in partnership with MO KidsFirst, will continue to offer and/or support and promote partner offerings of the Stewards of Children training for LPHAs and other community partners. The Stewards of Children framework teaches how to prevent, recognize, and react responsibly to child sexual abuse. The framework is built on the foundation of The 5 Steps to Protecting Children, uses real people and real stories to show how to protect children and is available in English and Spanish.
 - The Schuyler, Putnam, and Clark County health departments will work with organizations serving youth to determine if they have child-adult contact policies and if not, help them to develop policies and provide trainings to staff.
- Violence
 - The Kansas City Health Department will work with the KC Blueprint for Violence Prevention and Healthy Communities. KC Blueprint was developed by the Violence Free Kansas City Committee (VFKCC), a citywide multisector collective impact effort of public and private entities with the mission to ensure that violence prevention and deterrence efforts are coordinated and rooted in public health and community resilience approaches. The goal of the KC Blueprint is to reduce incidence of violence and trauma affecting youth and families and ultimately heal the city together. (KCBlueprint, 2020)
 - The Linn County Health Department will work with Dr. Shayla Sullivant from Children’s Mercy in KC to bring her Prepped and Ready Program, including a home safety component and safe storage of firearms, to their communities.
- Lead poisoning
 - The Johnson County Health Department will work with local child care providers to develop lead testing policies within their organizations and provide on-site lead testing for children along with education and referral to resources as needed. Child care providers that develop policies and practices will be recognized by the health department with a “seal of greatness”.

The Child Care Health Consultation (CCHC) Program will continue to provide consultations and trainings for child care providers and health promotions for children in child care on a variety of injury prevention topics to promote safe child care environments, encourage healthy and safe behaviors, and prevent injuries in children. Consultations for child care providers will assist in the assessment of health and safety environments using evidence-based tools, development and review of policies, implementation of health and safety procedures, promoting active supervision, and utilizing safe and developmentally appropriate equipment in the indoor and outdoor environments of the child care facility. Training and health promotion topics will include, but not be limited to: abuse and neglect, mandated reporting, behavioral health, emergency preparedness, CPR/First Aid, active supervision, medication administration, poisoning prevention, lead poisoning prevention, fire safety, gun safety, injury prevention, motor vehicle and car seat safety, playground safety, safe sleep, stranger safety, water safety, and sun safety. Health promotions will continue to provide children in child care with meaningful experiences regarding health and safety and injury prevention that can be implemented in their lives outside the child care facility, and provide educational materials for their parents/guardians. All CCHC program services will continue to be inclusive and promote family involvement.

Safe Kids coalitions will address priorities including child passenger safety, bicycle/helmet safety, crib safety, TV and furniture tip-over, pedestrian safety, poisoning, home safety, and other areas such as farm safety based on identified community needs. The coalitions will offer a broad array of activities including: providing cribs and car seats with parental education, conducting car seat checks and certification training for child passenger safety technicians (CPST), conducting media campaigns with prevention messages, and working with policy makers to address gaps in policies that could prevent injuries.

The DHSS Injury Prevention Program Manager will continue to represent District 5 (Central District) on the MO Child Passenger Safety Advisory Committee, maintaining regular contact with all CPSTs/inspection stations in the district, being available to sign off on seats for CPST/instructor recertification, mentoring new instructors, being the main point of contact when the Missouri Department of Transportation orders car for the area inspection stations, recruiting new inspection stations, and attending CPS Advisory Committee meetings. The MCH Director will continue to participate on the Missouri Brain Injury Advisory Council, MIVPAC, and the MO Council for Adolescent and School Health (CASH). The MCH Director, Injury Prevention Program Manager, MCH Program Manager, and MCH District Nurse Consultants will continue to serve on statewide and regional safety coalitions, such as the Missouri Coalition for Roadway Safety state and regional coalitions and the Occupant Safety Subcommittee, and partner with safety advocates to prevent intentional and unintentional injuries.

The violence prevention team in the Office on Women's Health (OWH) will leverage the Rape Prevention and Education Grant to promote shared risk and protective factors for violence prevention to prevent teen dating violence, sexual violence, and harassment in the middle school population in the state.

SPM #2 Suicide and Self-Harm – Promote Protective Factors for Youth and Families.

Mental Health

The DHSS School Health Program (SHP) will continue to partner with the Department of Mental Health (DMH), Department of Social Services (DSS), Department of Elementary and Secondary Education (DESE), and other agencies and organizations to identify training and resources, and to facilitate connections with school districts across Missouri. The SHP will support professional development for school health staff to implement best practice recommendations for becoming trauma informed and creating safe spaces for all students to attend school, including LGBTQ and other at-risk students.

Through the Show Me School Based Health Alliance partnership, the SHP will support school-based clinics to provide services, including mental and behavioral health services, on school campuses or nearby. These services are effective in providing comprehensive care, especially when established in partnership with a Federally Qualified Health Center (FQHC).

The SHP will host a two-day collaborative for 40 school nurses and social workers to learn best practices in suicide prevention. The focus will be on best practice strategies to promote students returning to school after a mental health crisis.

Inclusivity refers to the degree to which programs are sensitive toward, responsive to and encompassing of the diverse experiences and needs of all youth and families. The Adolescent Health Program (AHP) will continue to disseminate training to contractors and partners to improve inclusivity across youth-serving organizations. Improving inclusivity and the ability for adults to better understand and support youth will improve outcomes across health indicators. The AHP will also continue to provide Foundations trainings to school personnel across Missouri to help the districts evaluate and improve their health curriculums for inclusivity.

In conjunction with the Personal Responsibility and Education Program (PREP) and the Sexual Risk Avoidance Education (SRAE) grants, the AHP will continue to implement evidence-based teen pregnancy prevention and positive youth development programs across Missouri's highest need areas. The Teen Outreach Program (TOP), Becoming a Responsible Teen, Making Proud Choices, and Making a Difference programs will continue to improve not only the knowledge of Missouri's youth, but also their self-efficacy, health outcomes, and school outcomes. New programs will also be considered and piloted as needed.

The AHP will continue to work towards having adolescent input at the state-level. The AHP will continue to implement youth advisory councils and advisors as part of the teen pregnancy prevention grant contracts. Each contractor will be required to hire youth advisors or start a youth advisory council (YAC), and these youth will be part of a network the DHSS can reach out to for advice on issues facing youth. The AHP will work with contractors to grow skills related to developing YACs over the next few years.

In partnership with the OWH, the AHP will pilot a new sexual health curriculum developed for youth and young adults with intellectual and developmental disabilities. This population is up to seven times more likely to experience interpersonal violence in part due to a lack of quality sexual health education. Friendships and Dating (F&D), an evidence-based curriculum, will be piloted within a public school and a few out-of-home care facilities in Missouri to assess its quality and fit for Missouri's youth and young adults. F&D is shown to significantly decrease the incidence of interpersonal violence and increase social network size for those completing the program.

The AHP will continue to focus on Social-Emotional Learning (SEL) through the training and expansion of TOP Clubs across Missouri. The AHP will expand Missouri's SEL through continued Youth Thrive and SEL Institute trainings, which were started in FFY18 in partnership with long-time partner, Wyman, Inc. These trainings are targeted to youth-serving organizations such as schools, LPHAs, DHSS contractors, and social service agencies. The trainings teach the basics of adolescent brain development and trauma-informed care and increase the SEL knowledge of adults who work directly with youth.

The AHP will continue to work with Wyman, Inc. on the Teen Connection Project (TCP) to build communication skills, SEL, and connections between high school aged youth and their peers and adults. These protective factors will help achieve the goals of Missouri's Title V MCH State Action Plan. If an additional grant application is approved, the DHSS will partner with Wyman, Inc. to implement the program at a number of sites across Missouri, with the hope

that continued Title V MCH Block Grant collaboration and support will help sustain ongoing TCP growth and expansion.

The AHP will continue to leverage adolescent pregnancy prevention funds to work on adult/child relationships through the Connect with Me campaign. This campaign encourages parents/guardians, teachers, coaches, and all adults to have stronger relationships and deeper conversations with the youth they care about. Topics included in the conversation starter cards for the campaign include trauma, healthy body image, taking action to support health needs, and others. The AHP will work to expand the campaign to include a Connect with Me phone app, enabling the program to expand outreach capabilities and the variety of topics available, including expansion of the mental health section and addition of a diversity category.

Missouri's State Adolescent Health Coordinator (SAHC) will serve as the President for the National Network of State Adolescent Health Coordinators (NNSAHC), a resource to communicate ideas and build knowledge and expertise. Missouri is part of Region VII, and the four SAHCs collaborate to share information and provide similar messaging and trainings.

The Injury Prevention Program, in partnership with the AHP, will complete the pilot of the Navigating Your Child's Mental Health Crisis Toolkit. The toolkit provides comprehensive guidance for families with a youth in the midst of a mental health crisis. The toolkit was distributed to local school districts during the 2021-2022 school year. The school districts will pilot the toolkit and provide feedback to the DHSS during the 2022-2023 school year. Once the pilot is completed and any necessary changes are made, the toolkit will be available to all schools in the state.

The MCH Services Program will support LPHA and/or community partner efforts to provide education, screening, and referral for adolescent mental health needs. The Program will continue contracts with 32 LPHAs that identified prevention and reduction of suicide and/or self-harm in their local adolescent populations as the Priority Health Issue to be addressed in their FFY 2022-2026 MCH work plans. These efforts will include, but are not limited to, preventing substance use, preventing and reducing the impact of toxic stress, and building resiliency. Examples of LPHA planned contract activities include:

- Cass, Gasconade, Pettis and Ray county health departments will increase the number of certified Youth Mental Health and First Aid instructors and Youth Mental Health and First Aid trainings for parents, grandparents, school faculty, child care and medical providers, and others who provide services to children and families.
- Nodaway County Health Department will work with school districts to implement Character Strong, which provides research-based PreK-12th grade SEL curricula and professional learning services that positively impact lives.
- The Stone and Taney county health departments will use QPR, an evidence-based suicide prevention program, with various community organizations serving youth and adolescents, such as the Civil Air Patrol (CAP) Cadet Program and the Greater Ozarks Centers for Advanced Professional Studies (Go-CAPS). The CAP Cadet Program is a congressionally chartered, federally supported non-profit corporation that serves as the official civilian auxiliary of the United States Air Force. The Program transforms youth into dynamic aerospace leaders through a curriculum that focuses on leadership, aerospace, fitness, and character. As cadets participate in these four elements, they advance through a series of achievements, earning honors and increased responsibilities along the way. Many of the nation's astronauts, pilots, engineers, and scientists first explored their careers through CAP. Go-CAPS participants experience real world, project-based learning strategies through collaborations with business and community partners. These interactions enhance the learning experience by preparing students for college and careers.

In addition to the above activities, the Child Care Consultation (CCHC) Program will continue to provide trainings and consultations to help child care providers identify children with mental health needs, promote evidence-based protective factors for children and families, and address mental illness prior to reaching adolescence. Such training topics will include trauma-informed care, resilience, depression and anxiety, divorce, grief, separation anxiety, SEL, positive behavior support, positive discipline, healthy relationships in child care, and substance abuse awareness. Training topics for child care providers that focus on staff mental health and wellness will include suicide prevention and awareness, trauma-informed care, resilience, self-care, stress management, the relationship between physical and mental health, substance use awareness and prevention, and de-escalation in times of crisis. Consultations with child care providers will promote the implementation of policies and procedures that optimize the mental health of staff and children and provide referrals to outside resources as needed. CCHCs will continue to provide for children in child care health promotions that promote mental health in young children on the topics of bullying, emotional expression, anger management, regulation of emotions, sleep, screen time, empathy, self-esteem, celebrating differences and diversity, and living tobacco and drug free. CCHC program services will continue to provide evidence-based and educational resources for child care providers and families of children in child care that promote mental health, and provide children in child care with meaningful experiences, coping strategies, and mental health support that will benefit their lives inside and outside of the child care setting. Participation of parents/guardians of children in child care will continue to be encouraged in all CCHC services.

The violence prevention team in the OWH will leverage the Rape Prevention and Education (RPE) Grant to promote shared risk and protective factors for violence, suicide, and self-harm prevention. These components will be incorporated into new prevention strategies funded by RPE to be implemented in college and university settings.

The Missouri DSS launched a new Specialty Health Plan, called Show Me Healthy Kids, to help provide unified healthcare coverage to children and youth in DSS custody, former foster children, and individuals receiving adoption assistance payments. This specialized managed care plan, administered by Home State Health, will allow some of the most vulnerable members of MO HealthNet (Missouri Medicaid) to access a care network specifically designed to meet their needs. Coverage under the Show Me Healthy Kids plan began July 1, 2022. Individuals who qualify for coverage through Show Me Healthy Kids will automatically be moved to this plan from their existing health plan, or enrolled in this health plan the day they are approved for MO HealthNet (Missouri Medicaid) benefits. They will continue to receive their healthcare coverage through this plan as long as they are eligible. Eligibility groups for Show Me Health Kids include:

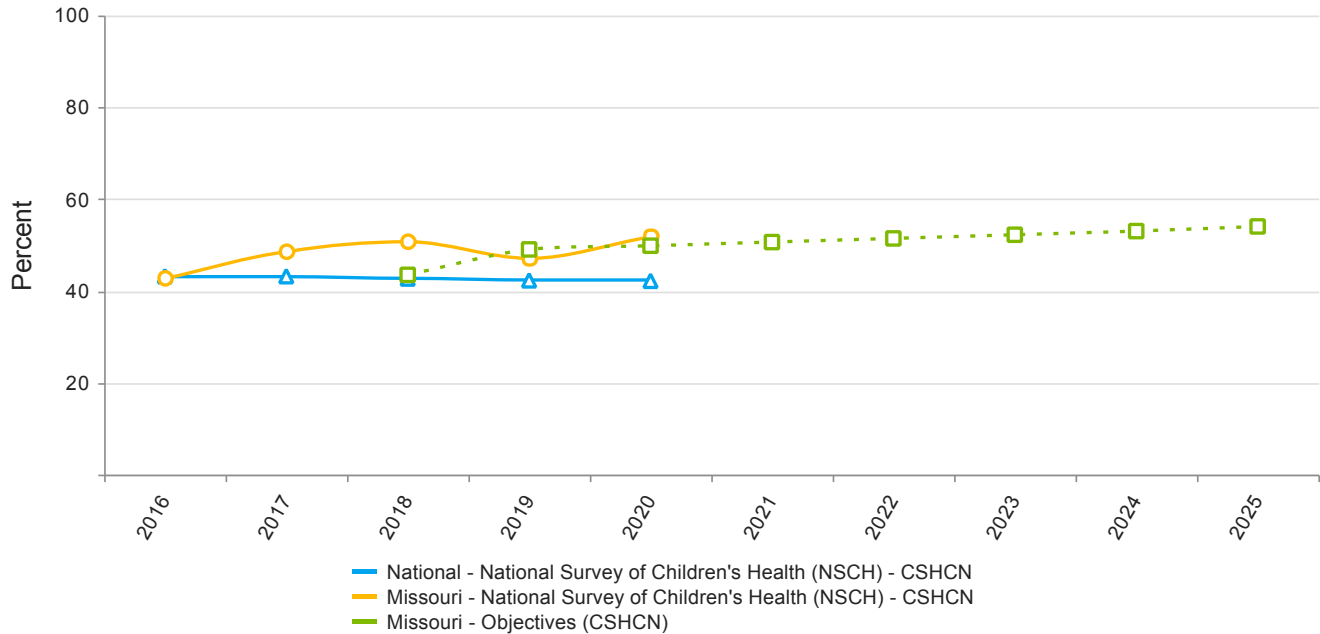
- Children in the care and custody of the Missouri Department of Social Services;
- Children or youth in alternative care;
- Children receiving adoption or legal guardianship subsidy;
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by MO HealthNet (Missouri Medicaid), and who meet other eligibility criteria; and
- Former foster care youth under the age of 26, who were in foster care on their 18th birthday and covered by Medicaid from another state, and who are not currently eligible for Medicaid coverage under another program

Children with Special Health Care Needs

National Performance Measures

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Indicators and Annual Objectives



NPM 11 - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	2018	2019	2020	2021
Annual Objective		43.5	49	49.8	50.6
Annual Indicator	42.7	48.6	50.6	46.9	51.9
Numerator	134,875	144,848	148,654	141,727	149,881
Denominator	316,087	298,327	293,652	301,956	288,780
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		43.5	49	49.8	50.6
Annual Indicator	48.6	50.6	46.9	51.9	51.9
Numerator	144,848	148,654	141,727	149,881	149,881
Denominator	298,326	293,652	301,956	288,780	288,780
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.4	52.2	53.0	54.0

Evidence-Based or –Informed Strategy Measures

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			1,800
Annual Indicator	1,682	1,822	1,057
Numerator			
Denominator			
Data Source	MO DHSS Programs	MO DHSS Programs	MO DHSS Programs
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2,000.0	2,400.0	2,800.0	3,000.0

State Action Plan Table

State Action Plan Table (Missouri) - Children with Special Health Care Needs - Entry 1

Priority Need

Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.

NPM

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Objectives

By 2025, increase the percent of children with and without special health care needs, ages 0 through 17, who have a medical home from 50.0% (NSCH 2017-2018).

Strategies

Promote evidence-based management of acute, chronic, and/or complex child and adolescent medical conditions.

Promote coordinated systems across the child/family care continuum by promoting the medical home approach to care.

Partner and collaborate with various stakeholders to integrate the medical home approach across all population health domains.

Provide education and outreach on the importance of medical home to DHSS programs, subcontractors, and partners that serve families with children in the household.

Build program and policy evaluation capacity.

ESMs

Status

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

Active

NOMs

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

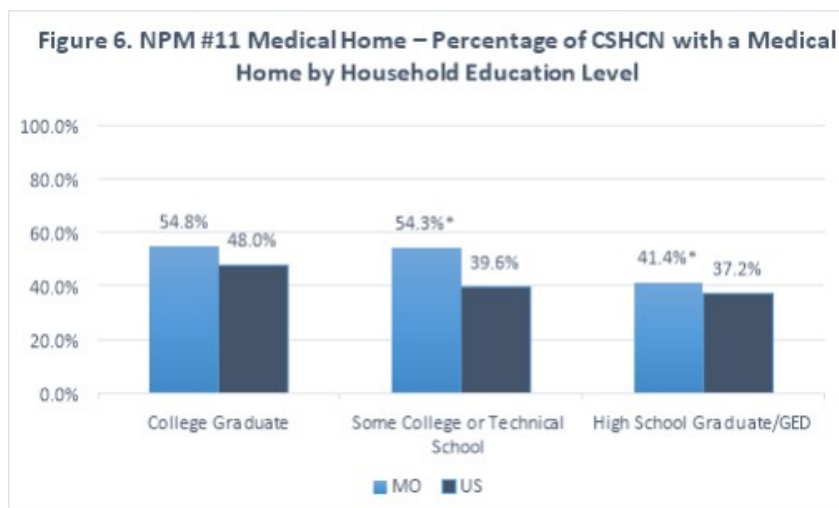
NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Children with Special Health Care Needs - Annual Report

NPM #11 Medical Home – Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.

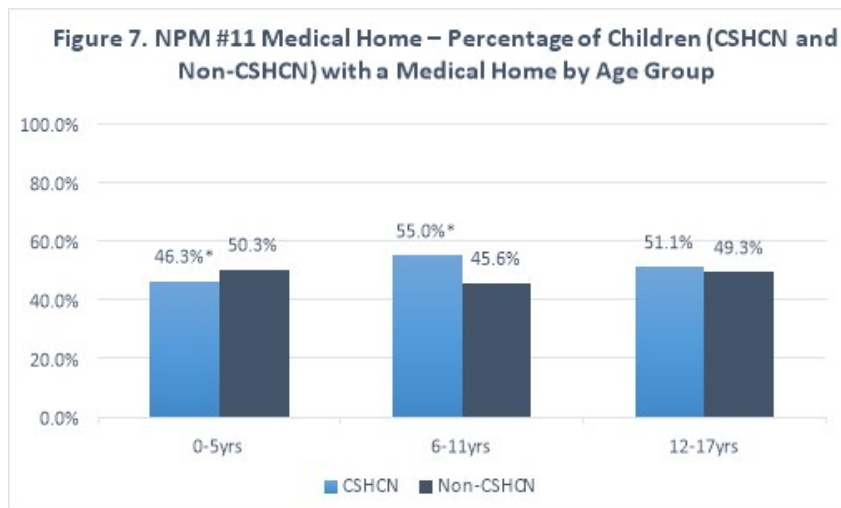
Please note: for clarity in this domain narrative, “cyshcn” refers to all children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children generally. “CYSHCN” refers to the Children and Youth with Special Health Care Needs Program.

According to the 2019-2020 National Survey of Children’s Health (NSCH), an estimated 51.9% of Missouri cyshcn had a medical home in comparison to 42.2% nationwide. In addition, the percentage of cyshcn with a medical home varied by socio-demographic characteristics. Non-Hispanic White cyshcn in Missouri (51.7%) had a medical home more frequently than their national counterparts (47.1%). College graduate households in Missouri had a notably higher proportion than high school graduate or GED households (Figure 6). Nationally, children 0-5 years (38.9%) were less likely to have a medical home compared to 12-17 year olds (43.9%). In Missouri, younger children less commonly had a medical home (Figure 7). Cyshcn with only public insurance were less likely to have a medical home (47.7%*) than their privately insured counterparts (55.2%). However, the percentage for Missouri cyshcn with only public insurance that had a medical home was higher than their national counterparts (34.7%). Single parent households (52.1%*) in Missouri had a lower proportion of cyshcn with a medical home than their two-parent married household counterparts (54.4%).



Nationally, among children without special health care needs, 47.9% received care through a medical home compared to 48.5% in Missouri. Both percentages are below the HP2020 target of 63.3%. Similar to cyshcn, the proportions of Missouri children without special health care needs also varied by socio-demographic characteristics. Non-Hispanic Whites (51.1%) had the highest proportion receiving care within a medical home compared to Hispanics (35.7%*) and non-Hispanic Blacks (43.9%*). Non-Hispanic Blacks also had a higher percentage in Missouri than they did nationally (38.2%). Missouri children from single parent households (48.6%) less frequently had a medical home than their counterparts from two parent, married households (50.7%). Furthermore, children with private insurance only (53.9%) were more likely to receive care in a medical home than uninsured children (17.1%*) and children with public insurance only (49.1%*). College graduate households in Missouri (60.6%) had a higher proportion of children without special health care needs with a medical home than some college or technical school (41.7%) and high school graduate or GED households (38.4%). This proportion was slightly higher than the national

proportion for college graduate households who have a medical home (60.0%).



Medical Home Strategies

Special Health Care Needs (SHCN) Initiatives

SHCN programming conducted comprehensive assessments in collaboration with participants and their families to identify strengths and address needs. Service coordination is an essential service for people with complex conditions and needs. Service coordination provided through SHCN is culturally competent, collaborative, proactive and comprehensive, and provides assessment through home visits and linkage to resources that enable individuals to obtain the best possible health and greatest degree of independence. The primary mechanisms of service coordination are individualized assessment, planning, plan implementation, monitoring, and transitioning. In State Fiscal Year 21, 99% of SHCN participants enrolled in the Children and Youth with Special Health Care Needs (CYSHCN) Program, Healthy Children and Youth (HCY) Program, and Medically Fragile Adult Waiver (MFAW) Program reported having a medical home. For participants/families without a medical home, Service Coordinators provided educational materials to help participants obtain coordinated, ongoing, and comprehensive care. SHCN utilized professional interpreters for phone conversations and home visits. SHCN had multiple documents available in various languages including: Arabic, Bosnian, Burmese, French, Russian, Somali, Spanish, and Vietnamese. SHCN Service Coordinators assisted participants/families in navigating the complex health care system and collaborated with external agencies and support systems to ensure coordinated care for participants and families, including access to information systems for shared data. Service Coordinators were regionally based throughout the state, ensuring easy access for participants/families and expertise in local resources. In addition, for youth who received in home services and were aging out of the HCY Program, SHCN collaborated with management staff of the DHSS Division of Senior and Disability Services (DSDS) and the Department of Mental Health (DMH) to increase coordination among state agencies delivering adult home and community-based services. In Missouri, services for children are more robust than services for adults. Furthermore, adult services are fragmented among three state divisions, which have disparate service structures and eligibility processes. SHCN Service Coordinators took the lead in working with participants/families to schedule transition meetings with staff from the DSDS and DMH. The transition meetings were coordinated to accommodate the participant's/family's needs. During the transition meetings, each agency representative explained services available through their agency and encouraged participants/families to ask specific questions regarding their situation and needs. Transition meetings helped participants/families make informed decisions as they obtained information and identified available resources.

In Missouri, people who are elderly, blind, or disabled are given the option to utilize Medicaid through Managed Care or fee for service. Medical reviews are conducted to determine if individuals qualify to 'opt out' of Managed Care

Medicaid. However, individuals utilizing SHCN services through HCY or CYSHCN are exempt from the medical review and are automatically qualified to choose either Managed Care or fee for service. Ongoing communication between MO HealthNet (Missouri Medicaid), Managed Care Companies, provider agencies, and SHCN is required to ensure effective service provision. Individuals may switch between Managed Care Companies and/or fee for service Medicaid, which may inadvertently impact the services they receive. Not all fee for service Medicaid provider agencies are contracted with Managed Care Companies, so families need to prioritize and choose the option that enables them to utilize the providers who are most important to them. For participants enrolled in the HCY Program, SHCN assisted with authorization of in-home services to avoid gaps in services when changes in coverage occurred. In addition, for participants who did not receive in-home services through the HCY Program, SHCN provided MO HealthNet enrollment information on a weekly basis to ensure participants of the CYSHCN Program were provided the opportunity to choose between Managed Care Medicaid and fee for service Medicaid. The coordination of care for these individuals is extensive but necessary to ensure access to essential services.

Service Coordinators for the CYSHCN and HCY Programs completed the Service Coordination Assessment (SCA) with program participants and their families. The SCA includes components consistent with the Federal data collection regarding participants and families partnering in decision-making. 92% of SHCN participants and families enrolled in the Adult Brain Injury (ABI), CYSHCN, HCY, and MFAW Programs reported they were 'very satisfied' with SHCN services. SHCN collaborated with partners to coordinate services for participants. SHCN Service Coordinators and Family Partners referred participants and families to MO HealthNet and assisted them in navigating the Medicaid system. The SCA also included components which assess insurance availability for medical, vision, and dental services. The SHCN information system linked with the Department of Social Services (DSS) data system to obtain the current Medicaid status of participants. In addition, SHCN received referrals from the Missouri Balanced Incentive Program, also referred to as Missouri Community Options and Resources (MOCOR), for cyshcn.

Service totals for SHCN FY21 included:

- CYSHCN Program served 768 CYSHCN.
- HCY Program served 1,308 CYSHCN.
- Family Partnership served 9,416 individuals (including family members of CYSHCN, community members and friends of CYSHCN families as well as advocates and professionals working with CYSHCN).

SHCN staff and programs continued to operate with several adjustments due to COVID-19; ensuring coordinated, comprehensive, ongoing services continued for participants and families. Continuing changes initiated in March 2020, all home visits were suspended, and replaced with phone contacts. SHCN staff collaborated with MO HealthNet staff to prepare 1135s and Appendix Ks to request Medicaid State Plan and Waiver amendments from Centers for Medicare & Medicaid Services (CMS). In addition to suspending all in-home visits, the following allowances were approved for in-home services: 1) acceptance of verbal consent rather than handwritten signatures, 2) when no other caregiver was available, personal care and waiver attendant care could be provided by family members who did not live in the same residence and were not legally responsible for the participant and were employed by an agency, 3) private duty nursing could be provided by family members who were licensed nurses and employed by an agency, including those who lived in the home and were legally responsible for the participant, and 4) graduate nurses were allowed to provide private duty nursing services. These amendments required collaboration with MO HealthNet, as well as other state programs, to ensure consistency in allowances to reduce confusion for individuals who received services through multiple programs. SHCN established protocols and implemented processes for communicating notifications and modifications to staff, stakeholders, and participants/families. SHCN consulted with MO HealthNet and Missouri Medicaid Audit and Compliance (MMAC) to ensure acceptance of electronic signatures from SHCN staff and adjusted forms to allow electronic entry. SHCN shifted training protocols for new staff to adjust to the remote workforce. Service authorization adjustments were implemented frequently due

to staffing issues, changes in family schedules, school closures, and exposed or sick participants, family members, and/or staff members. In addition, SHCN staff members received multiple inquiries related to COVID-19 from families and providers, and they provided education on precautions, testing sites, and vaccinations. These activities began in March 2020 and continued through FY21.

SHCN contracted with MO Kids Assistive Technology (KAT) for improved access and independence of cyshcn. In FY21, the assistive technology services and devices provided through KAT were coordinated with a total of 78 entities (families, medical professionals, service coordinators, and schools) for 29 children across the state of Missouri. Projects included communication and mobility devices, hearing and visual devices, seating and mobility enhancements, and home and vehicle modifications. KAT was able to leverage funds from 22 different sources, totaling \$136,144, to supplement Title V MCH funds. Communication with families, contractors, and Service Coordinators ensured that the projects were completed satisfactorily in accordance with the Americans with Disabilities Act.

Family Partners

Family Partners provided educational materials to newly enrolled SHCN program participants to increase awareness of the importance of a medical home for children with and without special health care needs. Family Partners also collaborated with key stakeholders, such as pediatric health care systems, to increase access to care for cyshcn by educating families about the importance and benefits of a medical home. Additionally, the Family Partners have continued to develop a webpage dedicated to medical home resources. The SHCN Family Partnership disseminated information to families through quarterly E-News emails and bi-annual printed newsletters to keep families informed about statewide activities as well as important information regarding supports for families. Issues featured information and tools centered on the life course to assist families in exploring their options for resolving issues and overcoming barriers, creating a vision for the future, and connecting with the resources they need to make their vision for a good life possible. Family Partners assist families to resolve and overcome barriers that arise when talking care of CYSHCN. For example, they may share ideas on how to make it easier to travel with a person who has special health care needs or prepare for a conversation with a medical provider. In addition, information regarding the importance of a medical home for all children is included in each issue. Family Partners gathered input from families to determine the effectiveness of the information shared through the printed newsletters and E-News emails.

The Southeast Family Partner served as the AMCHP Family Delegate for Missouri and participated in the AMCHP Leadership Lab Family Partner Cohort. In this capacity, she participated in:

- AMCHP Leadership Lab Cohort activities as well as family engagement activities within SHCN and Title V programs, and
- The annual block grant review in November 2020 and the virtual AMCHP Conference in May 2021.

The Southwest Family Partner served as:

- A family advocate for the Pediatric Palliative Care (PPC) Task Force through the National Coalition for Hospice and Palliative Care, which is funded by a grant from the Cameron and Hayden Lord Foundation. The task force focuses on identifying field priorities, setting field strategies, and coordinating with organizations across the country to route resources to PPC activities designed to improve national alignment and impact. It is not the intention or role of the task force to implement these projects directly but rather to offer a road map for improving children's access to high-quality palliative care.
- A member of the Council for Adolescent and School Health (CASH). Attending these meetings provided the opportunity to offer the family perspective as well as network with other professionals around the state ranging from social workers to school counselors.

The Northwest Family Partner served as:

- The secretary for the Missouri Parent Advisory Council (PAC). The purpose of the PAC, through Missouri's Early Care and Education Connections at the newly established Department of Elementary and Secondary Education (DESE) Office of Childhood (OOC), is to engage and empower Missouri families. Members of the PAC are family leaders who have experience working with agencies that provide services to at-risk families with young children. Every PAC member receives training in Strengthening Families™ and the *Protective Factors Framework through Strong Parents, Stable Children: Building Protective Factors to Strengthen Families* and may facilitate future leadership trainings;
- A member of the Child Abuse and Neglect sub-committee for Missouri; and
- Participated in family engagement activities within SHCN and Title V programs.

The Northeast Family Partner:

- Served on the advisory committee for the Heartland Genetics Service Network to provide the family perspective. The Heartland Regional Genetics Network is focused on ensuring the best possible outcome for individuals with heritable disorders and optimizing the health of the population throughout the life cycle by improving understanding and awareness of genetics, expanding access to healthcare, and translating new findings to improve the quality of care within an eight-state region;
- Served as a member with the HOPE for Franklin County Coalition and Healthy Schools Healthy Communities, which promotes alcohol, drug and suicide prevention; and
- Continued to work with the St. Louis Resource and Respite Coalition to collaborate with over 50 organizations to assist families of cyschn.

The Family Partners for Deaf and Hard of Hearing:

- Connected with families as they navigated programs and resources after their children were diagnosed with hearing loss. The Family Partners shared additional resources and parent support;
- Continued to develop connections with professionals across the country by participating in Hands & Voices Family Leadership in Language and Learning Center (FL3) and Family-to-Family Communities (F2FC) Deafblind Communities Project events;
- Served as a member of the Special School District Parent Advisory Council (SSD PAC) executive committee and gained knowledge and insights regarding processes of special education and became a voice for other families by sharing concerns and providing feedback at PAC meetings; and
- Facilitated meetings for the F2FC for Families with Children who are Deafblind with Complex Needs Support Group.

A SHCN Family Partner continued to participate with the Missouri Childhood Lead Poisoning Prevention Program (CLPPP) project. Family Partner collaboration was initiated with the Maternal Child Environmental Health (MCEH) Collaborative Improvement and Innovation Network (CoIIN) project. Though the MCEH CoIIN ended in the summer of 2020, several activities initiated for the CoIIN were continued and further developed as ongoing projects. Some examples are expanding targeted community outreach campaigns in low testing or high-risk areas of the state; review of outreach materials; and assistance with participation in a variety of presentations and planning sessions. The continued relationship with the Title V Program and Family Partners is a valued component in state endeavors to successfully increase the number of infants and children who have access to a coordinated care system that addresses their needs as a result of exposure to lead, ultimately decreasing maternal and child morbidity and mortality associated with lead exposure. In FY21, Title V funding was provided to cover, in part, some of the costs for increasing lead education in the communities, lead testing of children, and lead abatement activities.

The Missouri Family to Family Health Information Center uses the Life Course Framework in the development of a networking folder. This framework is used in webinars, which can be viewed by anyone at any time or viewed at host sites where families and professionals can learn from each other and discuss how the topics affect their lives. Using the Life Course Framework encourages families to create their vision for the future and supports professionals in thinking about how they are supporting families to build a vision while meeting their current needs. SHCN utilized Title V funds to support the printing and dissemination of the folders and Life Course materials for families of cyshcn.

Dental Home

The Office of Dental Health (ODH) continued to implement the Preventive Services Program (PSP) in Schools for the Severely Disabled under its ongoing agreement with DESE. The PSP provided an oral health screening by a dental professional, two doses of fluoride varnish for protection against tooth decay, and a referral to a local dental provider for care among children identified with a dental need. The referral to a local dental provider was to ensure identified needs are addressed and to link children to a dental home. Dental visits are recommended at least once or twice a year for all children and are especially important for cyshcn as they may have behavioral, dietary, or physical complications that affect dental health.

Ordinarily, the PSP educates children about good oral hygiene at an educationally appropriate level. For the Schools for the Severely Disabled, the oral health education is directed toward school caregivers and parents of students that have physical and/or intellectual disabilities. Part of this education is an emphasis on connecting children to a Dental Home regardless of whether a dental issue is identified at the time of the screening. Children also receive toothbrushes and toothpaste, which may be left at school or taken home. The target each year is to reach all 34 schools and serve approximately 300 students. Due to Coronavirus, no students were reached because schools restricted visitors or parents did not give consent for their child to be seen. ODH's oral health consultants were available to advise on any dental issue a student had. Oral health supplies, education, literature and fluoride varnish were available to any child who was not screened due to the pandemic.

ODH worked with the Missouri Coalition for Oral Health, which is coordinating a collaboration effort between Missouri's Developmental Disabilities Council, DMH and the University of Missouri-Kansas City Dental School, to educate dental professionals, thereby increasing access to care for cyshcn. Several meetings were held throughout the year to increase collaboration among these groups and discuss access to care for this population.

The Elk's Mobile Dental Program provided specialized dental services to individuals with Intellectual and Developmental Disabilities (I/DD). The program operated in 17 locations around the state, including in many rural areas where access to a Dental Home for individuals with I/DD is limited. Furthermore, the Elk's team is specially trained and equipped to serve individuals with I/DD, which increases compliance with regular and urgent dental treatment over time. The mobile unit is wheelchair accessible and sets up in a central location to reduce the burden and disruption of transporting individuals with I/DD. In ten of the last fourteen years, general revenue was available to support the program and paid for about 950 patient visits and 9,000 procedures. In addition to state funds, the Elk's Benevolent Trust, a non-profit organization, is a resource for financial support for the program. The Elk's Benevolent Trust would provide supplemental funding so adults and children with disabilities receive needed dental care. It is important to note that the Elk's Mobile Dental Program also accepts Medicaid, which helps stretch the funding. For some individuals, the program is their dental home due to a shortage of dental professionals that accept Medicaid as a form of payment and/or the reluctance of many dental teams to treat individuals with certain I/DDs. Through a program not supported by Title V MCH funding, ODH collected data from the Elks visits in 2019, 2020, and 2021. The data was used to create *The Elks Report*. ([Missouri DHSS \(mo.gov\)](https://missouri.dhss.mo.gov)) The report marked the first time in Missouri that data was been collected, analyzed, and disseminated in a formal report. This report is the only place to access dental information for cyshcn. The report surveyed 508 cyshcn in both 2019 and 2020. Whereas a 2018-19 Basic

Screening Survey of 2,352 third graders showed that 30% of third graders without special health care needs had dental sealants, the *Elks report* showed that among the cyshcn surveyed, only 1% had dental sealants. Children and youth without special health care needs had an untreated decay rate of 29% compared to 39% among cyshcn. These statistics show more work needs to be done to provide oral health care to cyshcn.

Early Childhood Professionals

The OOC Quality Initiatives Section the DESE provides inclusion referral services, technical assistance, and training throughout the state to help families and caregivers of young children with special health care needs. United 4 Children contracted with the DHSS in FY21 and provided 138 on-site visits with 290.75 on-site visit hours. They provided 104 remote-only general technical assistance visits and 225 remote-only child-specific visits. Of the 29% of children/families who were referred for additional services at the 6-week follow-up, only 13.5% reported receiving additional services. An average of 84% of children served maintained or found new placements. Inclusion Specialists provided 46,799 direct outreach contacts in FY21.

Inclusion Specialists provide a variety of services for young children with special health care needs. The specialists:

- Assist families with locating appropriate child care that will successfully support the individual needs of their child.
 - This includes providing families with a list of licensed or regulated child care facilities who have the ability to work with their child. We want parents to make the choice that best fits with their wishes, and by narrowing down who has the ability to accommodate a specific need, the specialists are able to save the families a lot of time and frustration.
 - When the list does not produce a facility that is able to accommodate a specific need, the specialists reach out to a program to discuss the requirements of the child. Inclusion specialists make site visits to the program to strategize on how the facility can make minor adaptations in order to successfully include the child.
 - They offer follow up technical assistance until the facility is fully equipped to meet the needs of the child.
- Provide training to caregivers to develop the necessary knowledge and skills to appropriately meet the needs of the child in care.
- Connect families with other community resources as appropriate.
- Provide general classroom as well as child specific observations. After the observations, the specialists can provide technical assistance to the child care providers regarding the needs of the group or child. They help develop strategies and offer training as needed to further the knowledge and skills of the caregivers. In FY21, a center in the Eastern Region reached out as a teacher was struggling with behavioral issues of a particular child. A specialist observed the classroom and facilitated the process of drafting an intervention plan specific to child. The teacher and director were eager and felt that the suggested strategies would promote positive change in the classroom and help during difficult transitions. In the Southwest Region, a specialist conducted a classroom observation and a child was referred to other services. Additionally, the teacher and director added onsite speech therapy for a child with a speech delay. There are similar stories from the different regions where a specialist observed and created intervention plans that directly correlated to a child's behavioral or medical need. Providers, teachers, and directors are given these plans to follow, and it not only gives them a place to start but also gives them hope.

The Quality Initiatives Section continued to provide inclusion services to support children with special needs, which includes children with a perceived developmental disability and/or delay, health/mental health, or behavior issue. The Inclusion specialists assist families in locating appropriate care by providing resources and assistance so that

families are educated to make decisions in the best interests of their family and child. They offer technical assistance to child care programs so that children with special needs can maintain placement as they grow and develop, thereby reducing preschool expulsion. Inclusion Specialists offer training to child care providers as new caregivers enter the workforce and as the needs within their programs change when new children are enrolled.

When providing inclusion services to families and children, specialists have identified that many of the children with behavior concerns have also experienced some form of trauma. Developing the child care workforce to better identify the signs of trauma in children helps providers better meet the needs of the children in their care. Inclusion Specialists have begun to deliver evidence-based training to child care providers and families in order to educate them on the effects of trauma in early childhood and to identify how children's behaviors may be affected by trauma. The training further addresses the stress placed on children in the foster care system and ways caregivers can support children as they transition between homes.

In FY21, the State's current Inclusion Support (IS) project was expanded to include the addition of an Inclusion Specialist and a Social-Emotional Learning (SEL) project, which is an additional component of the larger IS project. The IS project provides an element of prevention in the training delivered to teachers, and in the knowledge teachers gain from on-site consultation that can be carried over to new challenges. However, the primary focus of the IS Project is intervention. Inclusion Specialists are asked to help a family or a provider respond appropriately to a challenge occurring at a specific point in time. The intervention focuses on helping the teacher work with a particular child or situation. To most effectively prevent preschool expulsions and the short and long-term dangers they present, a more comprehensive and proactive program is needed. The SEL Project provides this support. A few of the main components of the program are:

- Four, day-long initial training sessions (one day a week for four weeks). The training focuses on an understanding of how children develop socially and emotionally, and how teachers can facilitate this development in real, practical ways. It is based on the research-based Pyramid and Conscious Discipline models.
- With family permission, the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) is administered to all children enrolled in classrooms participating in the project in order to identify children at greater risk of social-emotional delay. This could involve coordination with the Missouri Milestones Matter (MMM) project discussed in the Child Health domain.
- Completion of classroom action plans to address environment, relationships, and social emotional teaching strategies. Three specific pro-social skills are identified and taught to children. The action plan outlines individualized specific steps to be taken.
- Completion of individual plans for children identified as being at-risk.
- A minimum of four on-site observation/consultation visits from a Project Specialist over a nine-month period to facilitate implementation of plans, and support teachers through challenges that arise. Progress towards goals is made in between visits with sessions focusing on coaching specific strategies, observation for specific children, etc.
- Two Saturday half-day follow-up meetings to network and problem-solve with other participants.
- Administration of ASQ:SE at the conclusion of the project to all children screened at the beginning of the project and are still enrolled in the classroom.
- If all training/meeting components are completed, each participant receives a total of 32 approved training clock hours.
- Participants receive a comprehensive training manual and hands-on materials related to curriculum implementation.
- Program administrators attend a half-day session so they can support teachers' learning.

The Child Care Health Consultation (CCHC) Program provided training and consultation to child care providers at regulated and unregulated child care facilities on topics around health and safety, which included topics related to young children with special health care needs such as autism spectrum disorder, asthma, food allergies, seizure disorders, traumatic brain injury, and diabetes. The CCHC program also provided training and consultation to child care providers on inclusion of young children with special health care needs in child care activities. The program also provided consultations for child care providers to assist in the development of individualized health care plans (IHPs) and making referrals to outside resources such as MO HealthNet for Kids, developmental screening, and WIC. The CCHC Program provided 56 hours of training and consultation for health care providers on special health care needs, inclusion, and referrals to WIC and MO HealthNet for Kids. The program also provided 38.5 hours of health promotion for children in child care that provided developmentally appropriate health and safety lessons on topics related to young children with special health care needs. One example of these health promotions is 'Friends with Food Allergies', where children are encouraged to show empathy and kindness to children with food allergies, to not share food with other children without adult permission, and how to recognize an allergic reaction and get help if one of their peers is having an allergic reaction. Other health promotion on this topic included bullying, positive behavior support, self-esteem, celebrating differences, and empathy. CCHC program trainings and services are inclusive of adults and children of all abilities. The program encourages family engagement in program services by inviting parents/guardians of children in child care to attend trainings and consultations, and health promotion provided to child care providers and children in child care respectively. The capacity for LPHAs to deliver CCHC program services was severely impacted by the ongoing pandemic.

The CCHC program increased access to information and resources regarding the physical and emotional care of young children with special health care needs, promoted family participation in community-based organizations, and increased inclusion of children with special health care needs in child care facility activities. As a result of these trainings, children with special health care needs are safer in their child care environments, and their physical, social, and emotional health is optimized. Child care providers are also more knowledgeable of services available within the community and can refer more children and family to health and safety services.

DESE is developing an early childhood system that is family friendly and ensures every young child receives services needed. The work undertaken by this new Office includes the development of an Early Childhood Integrated Data System and a coordinated Early Care & Education system with a place for every family to access resources and services that promote safe and healthy learning environments for young children by supporting ongoing community leader activities like stakeholder engagement, relationship building and coordination across the state. This work builds off work of the Early Childhood Comprehensive System (ECCS) that was led by DHSS for several years. A new grant, "ECCS Health Integration: Prenatal to 3 Program" for \$255,600/year for the next 5 years, was awarded to Missouri in August 2021. This funding will support the ECCS program in leading the first integration of health needs, resources, and systems into the existing Statewide Early Care and Education (ECE) Strategic Plan and will build on current collaborative efforts to increase the impact for the prenatal to three population. The ECCS grant, in collaboration with the PDG B-5 grant, is currently conducting a system assets and gap analysis and network analysis of the early care and education and health care systems by the end of the second grant year. Upon its completion, DESE will work with the ECCS Advisory Council and other partners to determine the best way to integrate its findings into the strategic plan.

School Health

School nurses are a component of the medical home; assuring students have insurance, and that children with a potential for a life threatening event (such as a seizure, asthma flare, anaphylaxis event, alteration in blood sugar), or a special health care procedure (such as gastric feeding, catheterization, or dressing change) have written procedures and emergency action plans in place. These plans are developed in collaboration with the

parent/guardian and approved by the medical provider.

The School Health Program (SHP) continued to provide consultation, training, resources, and support to Missouri's school nurses on topics they encounter. SHP prepares an annual summary report from data collected by school nurses in the public, charter, private, and parochial schools, including the nurse to student ratio and the number of students with special health care needs and/or chronic health conditions. This report is shared with stakeholders to inform them about what students and school nurses need to promote student health. The SHP actively encouraged assessment of student insurance status and shared the data in the annual special health care needs/chronic health conditions report. (<https://health.mo.gov/living/families/schoolhealth/pdf/studentswithdiseaseandconditions.pdf>)

School nurses are also educated about Mo HealthNet and other community health resources, including FQHCs, in order to facilitate their role in promoting access to care and health services resources within a medical home model. Due to the pandemic, the SHP pivoted the annual workshop for new health office staff to a virtual format. The workshop provided training on hearing and vision screening, managing children with chronic health conditions in the school setting, writing emergency management and 504 plans, being a part of the Individual Education Plan (IEP) team, and developing IHPs for students. The SHP also provided guidance and consultation to all school nurses, referencing the Manual for School Health Guidelines, including a matrix of health care procedures permissible in the school setting. The SHP continued efforts to ensure that sessions offered at the Annual School Nurse Leader Collaborative, Spring School Nurse Association Conference, and the Coordinated School Health Coalition Conference are applicable to school health services, support best nursing practice, and actively promote the school nurse role in care coordination. During the pandemic, the SHP shifted to increased virtual learning opportunities and weekly office hours for lead school nurses. Office hour topics covered changes to Medicaid enrollment protocols during the pandemic, communication strategies. Additionally, there were discussions about the role of the school nurses in the virtual learning environment and adapting the IHP and the emergency action plan for school staff.

The SHP developed and piloted a new toolkit to support school nurses in parent interviews to develop effective action plans to address chronic health conditions in the school setting. The SN CHAT (School Nurse Chronic Health Assessment Tool) is a guide for conversations with the student's caregiver to learn about the unique health needs of an individual student and develop a personalized emergency action plan for staff and when needed an IHP. The goal is to prioritize parent engagement and student safety, and baseline data is available from the pilot for the number of IHPs and Emergency Action Plans (EAPs) before the SN CHAT intervention. It is expected that the number of EAPs will increase.

The SHP partnered with school board associations, principals' associations, Family and Community Trust as well as the MO HealthNet Division at DSS to promote access to care via Medicaid enrollment and awareness of FQHCs. The SHP continued to support and identify professional development opportunities for school health services staff by way of trainings, workshops, webinars and regional conferences to address Medicaid enrollment, Medicaid Managed Care, and other chronic health conditions.

The Missouri School Boards' Association (MSBA) leads an initiative to routinely include special services representatives and nurses on schools' emergency planning teams and for schools to consider the nature of disabilities and medical conditions represented by students and staff when creating, reviewing, and implementing emergency response plans. The SHP continued to engage and partner with MSBA on the emergency planning process for cyshcn. Work this year focused on the pandemic as it related to cyshcn. The SHP encouraged the utilization of MSBA's Emergency Planning for Students with Special Needs Task Force resources to inform and support school districts in improving their emergency planning process by considering the unique needs of each person within the school community. The "Emergency Planning for Students with Special and Functional Needs within the Context of School and Community Planning" was created and distributed to schools throughout the state.

The guide was presented at the Missouri Coordinated School Health Coalition Conference and the committee plans ongoing review of the guide to determine if revisions/updates are needed.

Newborn Screening

Since April of 2017, information about the importance of a medical home for children with and without special health care needs has been included in the Newborn Screening booklet and is distributed to new and expectant parents. The booklet is also distributed upon request to birthing hospitals, pediatric hospitals and clinics, LPHAs, WIC clinics, health care providers including midwives, high schools, home birthing centers, prenatal classes, businesses, and neonatal intensive care units. On average, approximately 4,000 booklets were requested by these entities per month.

The Missouri Newborn Hearing Screening Program (MNHSP) collaborated with Family Partnership to engage families in the Missouri Early Hearing Detection and Intervention (EHDI) system. Family Partners contacted parents of newborns who failed the newborn hearing screening to provide parent-to-parent support and encourage appropriate follow-up with a medical home. Family Partners continued to contact parents of infants newly diagnosed with permanent hearing loss to provide parent-to-parent support, review resources, and ensure awareness of the importance of the medical home in the care of a child who is deaf or hard-of-hearing. The Kansas City EHDI-Learning Community (KCEHDI-LC) worked towards increasing participation in the EHDI system while emphasizing the role of the medical home in management of the unique needs of infants with hearing loss through distribution of ten "EHDI Parent Resource Toolkit for Western Missouri" booklets and referring numerous families to the same booklet on the DHSS website.

Local Public Health Agencies (LPHA)

The MCH Services Program continued contracts with the LPHAs that supported a leadership role for LPHAs at the local level to:

- Build community-based systems and expand the resources those systems can use to respond to priority MCH issues;
- Provide and assure mothers and children (in particular those with low income or limited availability to health services) access to quality MCH services;
- Reduce health disparities for women, infants, and children, including those with special health care needs;
- Promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and
- Promote the health of children by providing preventive and primary care services for low-income children.

The LPHAs' efforts to fulfill the purpose of the MCH Services contract included activities and services that addressed the needs of children. One LPHA selected promotion of a medical home for children with and without special health care needs, ages 0 through 17, as the Priority Health Issue to be addressed in their FY2022-2026 MCH Services Contract Work Plan. The MCH Services provided education on medical home to the LPHA staff and technical assistance in the development of the contract work plan strategies, activities and system outcomes.

State Agencies and Partners

The overall goal of the Missouri Disability and Health Collaborative is to support individuals with intellectual disabilities to be included and have access to the full range of evidence-based physical activity and nutrition programs provided through public health programs within Missouri. Through the Missouri Disability and Health Collaborative, the DHSS-Bureau of Community Health and Wellness has continued to contract with the University of Missouri Kansas City Institute for Human Development to assist with reviewing and adapting existing nutrition and physical activity strategies to assure inclusivity of people of all abilities. Missouri has developed several strategies to

increase access to healthy foods and safe places to be physically active. However, few of these strategies have been designed to be accessible to people with intellectual disabilities or with the specific health needs of people with intellectual disabilities in mind.

In addition to the programs at the DHSS, there are several initiatives that contribute to Missourians receiving coordinated, comprehensive, and ongoing health care services throughout the state. In October 2011, the CMS approved Missouri's State Plan Amendment (SPA) establishing Medicaid reimbursement for health homes, making Missouri the first state in the nation to have an approved SPA for health home services. This first SPA established Community Mental Health Center (CMHC) Healthcare Homes serving individuals with serious mental illness. A companion SPA establishing Primary Care Health Homes (PCHH) in Missouri was approved in December 2011. Both SPAs were effective January 1, 2012. MO HealthNet, the DMH, and the community mental health systems collaborated to establish 'health homes' throughout the state's 29 CMHCs. Missouri's CMHC Healthcare Home Program was selected to receive the American Psychiatric Association's 2015 Gold Achievement Award in the category of community-based programs. The PCHH initiative provides intensive care coordination and care management as well as addresses social determinants of health for medically complex individuals. One aspect of the program includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model. The program emphasizes the integration of primary and behavioral health care in order to achieve improved health outcomes. In addition, MO HealthNet employs Registered Nurse Case Managers in the Evidence-Based Decision Support Unit. The unit established a pilot case management project made up of a multidisciplinary team that includes clinicians. The purpose of the pilot is to build infrastructure to support participants. Participants are selected for the pilot by utilizing an algorithm that determines participants with high needs and expenditures. The initiative builds a collaborative resource network to identify available resources. Care plans are developed for each of the participants in the case management program. Missouri's pediatric hospitals also provide services that support comprehensive, coordinated, and ongoing healthcare. The Journey's Program at the University of Missouri's Children's Hospital helps coordinate care provided by a child's health care professionals, community, and family to meet the physical, emotional, and spiritual needs of the child and family as they cope with complex medical conditions. Children's Mercy Hospital in Kansas City and St. Louis Children's Hospital provide family-centered care coordination through the Beacon Program and Clinic and the Pediatric Advanced Care Team (PACT) respectively.

The Childhood Lead Poisoning Prevention Program (CLPPP) staff continued to work with LPHAs and Mo HealthNet lead case managers to coordinate clinical and environmental services for families of children with elevated blood lead levels (EBL) in order to strengthen the role of primary care providers within the public health domain. Supporting public health relationships involving professionals with a variety of clinical and environmental expertise results in EBL declining more rapidly, therefore preventing further undesirable health effects. These supportive activities included:

- Leading education to health care providers, LPHAs, WIC programs, and many community activities;
- Documenting case managers, physicians, and other clinicians names and phone numbers in the records of children with EBL;
- Including Family Partners and representatives of various clinical and environmental disciplines when designing and planning new program strategies;
- Strategies to share and document pertinent case management information and actions across disciplines and with family/caregiver input resulted in provision of coordinated, effective, and efficient care; and
- Working with Family Partners to review program materials and planned activities.

In addition, CLPPP partnered with other Title V programs, health care providers, and DESE to establish well-coordinated efforts to provide early evaluation and referrals for services as well as ongoing monitoring for children with lead poisoning. Schools should have an early and ongoing role in the appropriate and timely follow-up of children with an EBL history. Schools can request, collect, and record EBL information for all children in their

district. Therefore, increasing timely referrals to DESE allows children who have an EBL history to have a variety of expanded and ongoing evaluation, monitoring, and intervention services such as: school nurses, Parents as Teachers (PAT), First Steps Early Intervention Programs, Head Start Programs, and other Special Services that develop IEPs. DESE program staff provided lead awareness education for all families/children in their districts, from birth to high school graduation, regarding the potential adverse effects of lead on the developing infant and child. Additionally, they shared information on services which are available to families and children to decrease the potential ongoing exposures and detrimental effects of lead. They worked with children's medical providers to assure that initial and ongoing health, developmental, behavioral, and cognitive assessments/evaluations were performed. DESE program staff either performed or referred children for various types of child health and developmental evaluations, and intervention services needed due to lead exposures that occur prior to and during their school years using IEPs and the many programs available through the school districts.

CLPPP staff also focused on lead hazard reduction in dwellings linked to a child with an EBL, including contracting with a licensed lead abatement firm in compliance with procurement processes. The program assisted low-income homeowners and landlords of subsidized housing to perform lead hazard reduction in dwellings linked to a child with an EBL. Funding was used to supplement training costs to encourage contractors to become licensed in lead abatement in which lack capacity. A recent national study shows that every dollar spent on lead hazard reduction has a \$17 - \$250 return on investment over the life a child.

*Please interpret with caution. The width of the 95% confidence interval exceeds 20 percentage points or 1.2 times the percent value. As a result, the percentage may not be reliable.

Children with Special Health Care Needs - Application Year

NPM #11 Medical Home – Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.

Please note: for clarity in this domain narrative, “cyshcn” refers to all children and youth who have or are at increased risk for chronic physical, developmental, behavioral, or emotional conditions and require health and related services of a type or amount beyond that required by children generally. “CYSHCN” refers to the Children and Youth with Special Health Care Needs Program.

The Bureau of Special Health Care Needs (SHCN) will continue to provide service coordination and conduct comprehensive assessments for participants/families, regardless of financial status. For participants/families who do not report having a medical home, Service Coordinators will provide educational materials to help them obtain coordinated, ongoing, and comprehensive care within a medical home. SHCN staff will receive training regarding the definition, principles, and key components of service coordination. SHCN staff and staff of contracted agencies will continue to discuss emergency planning with participants/families and provide them with materials to prepare for emergency situations to ensure safety and well-being during inclement weather events and other potential situations. To ensure culturally competent services, SHCN will continue to utilize professional interpreters for phone conversations and home visits. Educational materials, forms, and letters will be translated and available in various languages to accommodate the population served. In addition, staff and Service Coordinators of contracted entities will be provided the opportunity to participate in conferences and trainings focused on cultural diversity.

SHCN will continue to collaborate with the Department of Social Services (DSS), the Department of Mental Health (DMH), and the Department of Elementary and Secondary Education (DESE), as well as other external partners and agencies to obtain information about children and youth with special health care needs (cyshcn) who transition within the systems of care and to link participants/families with appropriate services and supports. Service Coordinators will continue to discuss life transitions with participants/families to help prepare for changes and navigating systems and supports. For youth who receive in home services and are aging out of the Healthy Children and Youth (HCY) Program, SHCN will begin discussing options for adult services with the participant/family at least one year prior to the participant's 21st birthday. In addition, SHCN will provide a list of participants who are aging out of the HCY Program with the Department of Health and Senior Service (DHSS) Division of Senior and Disability Services (DSDS)-Long-Term Services and Supports and DMH. SHCN will offer to conduct multi-agency transition meetings for participants who would be eligible for the Medically Fragile Adult Waiver (MFAW) Program after their 21st birthday in an effort to help the participant/family make informed decisions regarding services. SHCN staff and staff of contracted agencies will continue to access the MO HealthNet (Missouri Medicaid) information systems to determine the MO HealthNet status of participants and will refer participants/families who do not have MO HealthNet to DSS. In complex situations, SHCN will assist families by contacting DSS to expedite MO HealthNet applications and assist in resolving MO HealthNet access issues.

Service coordination is essential for people with complex conditions and needs. Service Coordinators for the Children and Youth with Special Health Care Needs (CYSHCN) and HCY programs will continue to complete Service Coordination Assessments (SCA) in collaboration with participants and families to address strengths and needs, which drives service plan development and implementation. The assessment tool includes medical home components which address whether a participant has:

1. A usual source of medical care when sick;
2. A usual source of preventive health care;
3. Visited a physician or specialist within the past year;
4. Health care providers that share information with each other and/or with non-medical providers;

5. Medical providers who spend enough time during visits, listening carefully, considering values and customs, providing needed information, and making the participant/family feel like a partner;
6. Knowledge on who to call for services;
7. The ability to get referrals when needed;
8. Received most services in the local community;
9. Adequate insurance to pay for needed services;
10. Access to language or mobility accommodations; and
11. Has been satisfied with general health services (physicians, hospitals, therapist, etc.), in-home provider agency services, and SHCN services.

The assessment tool also includes a component to assess if the physician who sees the participant most makes the participant/family feel like a partner and a component to assess if the participant/family feels like a partner with their SHCN Service Coordinator in making decisions regarding their services. In addition, the tool includes components to assess if participants/families are satisfied with general health services (physicians, hospitals, therapist, etc.), in-home provider agency services, and SHCN services. The SCA includes information regarding medical, dental, and vision insurance. SCA components related to adequate health insurance for cyshcn assess if insurance offers benefits and services that meet participants' needs, if the cost is considered reasonable, if the plan allows participants to see the providers needed, and if there was health insurance coverage all of the last 12 months. The SCA also includes components to assess if services are organized in a way that makes them easy to use by families of cyshcn. For participants who are 13 to 21 years of age, the SCA contains components to assess preparation for youth transitions including: if doctors or other health care providers talked with the participant/family about the changing health needs when the participant becomes an adult, if a plan for addressing changing needs has been developed with a doctor or other health care providers, if doctors or other health care providers have discussed having the participant eventually see a doctor who treats adults, and if the participant has received vocational or career training to help prepare for a job.

SHCN Family Partnership

Family Partners will contact newly enrolled SHCN program participants to inform them of the Family Partnership Program and to increase awareness of the importance of a medical home for children with and without special health care needs. Family Partners will continue to share medical home information through their listservs, as well as at resource fairs and conferences. Additionally, the Family Partners will develop a page on the Family Partnership website focused on medical home resources. Family Partnership newsletters will keep families informed of statewide activities, as well as important information regarding supports available for families. Family Partners will gather input from families to determine the effectiveness of the information shared through the newsletters.

Family Partners will continue to be involved in a variety of initiatives. The Southeast Family Partner will continue to serve as the AMCHP Family Delegate for Missouri and will participate in family engagement activities within SHCN and Title V MCH programs. The Southwest Family Partner will continue to serve as a family advocate for the Pediatric Palliative Care (PPC) Task Force through the National Coalition for Hospice and Palliative Care. The Northeast Family Partner will continue to serve on the advisory committee for the Heartland Genetics Service Network and work with the St. Louis Resource and Respite Coalition.

SHCN plans to continue to utilize Title V MCH funds to support the printing and dissemination of Missouri Family to Family Information Center Life Course materials and resource folders for families of cyshcn.

Family advocacy is critical in building coordinated and comprehensive systems. The Early Childhood Comprehensive Systems Health Integration P-3 grant (ECCS HIP-3) partners with Title V to maintain and support the Missouri Parent Advisory Council (PAC). Over the life of the grant, seven regional PACs will be established and

supported and will feed into a larger statewide PAC. The PACs will inform early childhood policy and procedure at local, regional, and state levels. Historically, the PAC also developed opportunities for parent and family involvement in their communities and across the state. The expanded regional model of the PAC will ensure that it is more inclusive and representative of all Missouri families with diverse needs and backgrounds.

Dental Home

The Office of Dental Health (ODH) will continue to implement the Preventive Services Program (PSP) in Schools for the Severely Disabled under its ongoing agreement with the DESE. The PSP provides an oral health screening by a dental professional, two doses of fluoride varnish for protection against tooth decay, and a referral to a local dental provider among children identified with a dental need. The referral to a local dental provider is designed to ensure identified needs are addressed and to link children to a Dental Home. Dental visits are recommended for all children at least once or twice annually and are especially important for children with special needs, as they may have behavioral, dietary, or physical complications that affect dental health.

Ordinarily, the PSP educates children about good oral hygiene at an educationally appropriate level. For the Schools for the Severely Disabled, the oral health education is directed toward school caregivers and parents of students that have physical and/or intellectual disabilities. Part of this education is an emphasis on connecting children to a Dental Home, regardless of whether a dental issue is identified at the time of the screening. Children also receive toothbrushes and toothpaste, which may be left at school or taken home. The target each year is to reach all 34 schools and serve approximately 300 students. Due to Coronavirus, the number of students reached could be less due to schools possibly restricting visitors or parents who may not give consent for their child to be seen. However, ODH's Oral Health Consultants will be traveling to the Schools for the Severely Disabled in order to screen and apply varnish as allowed. ODH's Oral Health Consultants will also be available to advise on any dental issue a student may have. Oral health supplies, education, literature, and fluoride varnish will be available to any child who does not receive a dental screening.

ODH is working with the Missouri Coalition for Oral Health, which is coordinating an effort to collaborate with Missouri's Developmental Disabilities Council, the DMH and the University of Missouri Kansas City Dental School to educate dental professionals, thereby increasing access to care for children.

The Elk's Mobile Dental Program provides specialized dental services to individuals with Intellectual and Developmental Disabilities (I/DD). The Program operates in 17 locations around the state, including in many rural areas where access to a dental home for individuals with I/DD is limited. Furthermore, the Elk's team is specially trained and equipped to serve individuals with I/DD, which increases compliance with regular and urgent dental treatment over time. The mobile unit is wheelchair accessible and sets up in a central location to reduce the burden and disruption of transporting individuals with I/DD. General Revenue has historically supported the Elk's Mobile Dental Program and pays for about 950 patient visits and 9,000 procedures. The state FY23 proposed state budget includes funding for the Elks program. In addition to General Revenue, the Elk's Benevolent Trust, a non-profit organization, also provides financial support for the Program. The Trust provides supplemental funding so adults and children with disabilities can receive the dental care they need. It is important to note that the Elk's Mobile Dental Program also accepts Medicaid, which helps supplement the funding. Due to the shortage of dental professionals that are willing to accept Medicaid as a form of payment and/or the reluctance of many dental teams to treat individuals with certain I/DDs, the program is the dental home for some individuals.

Early Childhood Professionals

The Office of Childhood (OOC) Quality Initiatives Section within the DESE provides inclusion referral services, technical assistance, and training throughout the state to help families and caregivers of children with special needs.

Inclusion Specialists provide a variety of services for children with special needs. The specialists:

- Assist families with locating appropriate child care that will successfully support the individual needs of their child.
 - This includes providing the families with a list of licensed or regulated child care facilities who have the ability to work with their child. We want parents to make the choice that best fits with their wishes, and by narrowing down who has the ability to accommodate a specific need, the specialist can save the families a lot of time and frustration.
 - When the list does not produce a facility that is able to accommodate a specific need, the specialists reach out to a program to discuss the requirements of the child in need of care. Inclusion Specialists make site visits to the program to strategize on how the facility can make minor adaptations to successfully include a child.
 - They offer follow up technical assistance until the facility is fully equipped to meet the needs of the child.
- Provide training to caregivers to develop the necessary knowledge and skills to appropriately meet the needs of the child in care.
- Connect families with other community resources as appropriate.
- Provide general classroom, as well as child specific, observations. After the observations, the specialists are able to provide technical assistance to child care providers regarding the needs of the group or child. They help develop strategies and offer training as needed to further the knowledge and skills of the caregivers.

The OOC Quality Initiatives Section will continue to provide inclusion services to support children with special needs, which includes children with a perceived developmental disability and/or delay, health/mental health, or behavior issue. The Inclusion Specialists will continue to assist families in locating appropriate care by providing resources and assistance so that families are educated to make decisions in the best interests of their family and child. They will continue to offer technical assistance to child care programs so children with special needs are able to maintain placement as the child grows and develops, thereby reducing preschool expulsion. Inclusion Specialists will continue offering training to child care providers as new caregivers enter the workforce and as the needs within their programs change with the children enrolled.

While providing inclusion services to families and children, specialists have identified that many of the children with behavior concerns have also experienced some form of trauma. Developing the child care workforce to better identify the signs of trauma in children will help providers better meet the needs of the children in their care. Inclusion Specialists have begun to deliver evidence-based training to child care providers and families to educate them on the effects of trauma in early childhood and to identify how children's behaviors may be affected by trauma. The training further addresses the stress placed on children in the foster care system and ways caregivers can support children as they transition between homes.

In FY21, the Inclusion Services (IS) project listed above was expanded to include the addition of another Inclusion Specialist and a Social-Emotional Learning (SEL) project, which is an additional component of the larger IS project. The IS project provides an element of prevention in the training delivered to teachers, and in the knowledge teachers gain from on-site consultation that can be carried over to new challenges in the future. However, the primary focus of the IS Project is intervention. Inclusion Specialists are asked to help a family or a provider respond appropriately to a challenge occurring at a specific point in time. The intervention focuses on helping the teacher work with a particular child or situation. To most effectively prevent preschool expulsions and the short and long-term dangers they present, a more comprehensive and proactive program is needed. The SEL Project provides this support. A few of the main components of the program are:

- Four, day-long initial training sessions (one day a week for four weeks). The training focuses on

understanding how children develop socially and emotionally, and how teachers can facilitate this development in real, practical ways. It is based on the research-based Pyramid and Conscious Discipline models.

- With family permission, the Ages and Stages Questionnaire: Social-Emotional (ASQ:SE) is administered to all children enrolled in classrooms participating in the project to identify children at greater risk of social-emotional delay. This could involve coordination with the Missouri Milestones Matter (MMM) project discussed in the Child Health domain.
- Completion of classroom action plans to address environment, relationships, and social emotional teaching strategies. Three specific pro-social skills will be identified and taught to children. The action plan outlines individualized, specific steps to be taken.
- Completion of individual plans for children identified as being at-risk.
- A minimum of four on-site observation/consultation visits from a Project Specialist over a nine-month period to facilitate implementation of plans, and support teachers through challenges that arise. Progress towards goals will be made in between visits with sessions focusing on coaching specific strategies, observation of specific children, etc.
- Two Saturday half-day follow-up meetings to network and problem-solve with other participants.
- Administration of the ASQ:SE at the conclusion of the project to all children who were screened at the beginning of the project and are still enrolled.
- If all training/meeting components are completed, each participant receives 32 approved training clock hours.
- Participants receive a comprehensive training manual and hands-on materials related to curriculum implementation.
- Program administrators attend a half-day session so they can support teachers' learning.

The Child Care Health Consultation (CCHC) Program will provide consultation and training for child care providers at regulated and unregulated child care facilities on topics around health and safety, which include topics relevant to young children with special health care needs, such as autism spectrum disorder, asthma, food allergies, seizure disorders, traumatic brain injury, diabetes, and inclusion. The CCHC Program will continue to provide consultations for child care providers to assist in the development of individualized health care plans (IHPs) with input from other health specialists and parents/guardians, and assist with referrals to outside resources such as MO HealthNet for Kids, developmental screening, and WIC. The Program will also continue to provide developmentally appropriate health promotion for children in child care on health, safety and topics relevant to young children with special health care needs,- including safe interactions with children with food allergies, bullying, positive behavior support, self-esteem, celebrating differences, and empathy. Program services will continue to provide evidence-based and educational materials regarding the physical and emotional care of CSHCN, optimize the physical, social, and emotional health of young children with special health care needs in the child care setting, and promote participation in community-based organizations. CCHC program services will continue to be required to be inclusive of adults and children of all abilities and family participation will be encouraged during all program services.

School Health

The School Health Program (SHP) considers school nurses as a component of a medical home; assuring students have insurance, and children with a potential for a life threatening event (such as a seizure, asthma flare, anaphylaxis event, alteration in blood sugar level), or a special health care procedure (such as gastric feeding, catheterization, or dressing change) have written procedures and emergency action plans in place. These plans are developed in collaboration with the parent/guardian and approved by the medical provider. The SHP will continue to promote the School Nurse Chronic Health Assessment Tool (SN-CHAT) to engage school nurses and parents in developing emergency action plans and IHPs.

The state school nurse consultant will continue to serve on the faculty for the Autism ECHO (Extension for Community Healthcare Outcomes). This learning opportunity shares autism specialist knowledge in a virtual learning network with a panel of interdisciplinary Missouri providers. Participants learn about best practices and evidence-based care for children with autism and developmental behavioral concerns, including detecting mental health concerns, diagnosing and treating common mental health disorders, making appropriate referrals, and supporting kids and teens in their treatment for mental health disorders. The ECHO meets every other week during the school year and targets school nurses and support staff.

The SHP will continue to provide consultation, training, resources, and support to Missouri's school nurses on health-related topics. The SHP prepares an annual summary report from data collected by school nurses in public, charter, private, and parochial schools, including the nurse to student ratio and the number of students with special health care needs and/or chronic health conditions. This report is shared with stakeholders to inform them about the needs of students and school nurses. The SHP also actively encourages assessment of student insurance status and shares the data in the annual special health care needs/chronic health conditions report. School nurses will continue to receive print materials, video presentations, and virtual conferences about MoHealthNet and other community health resources, including FQHCs to facilitate their role in supporting families to access health care and other health care services and strengthen their role in the medical home model. The SHP will continue to conduct an annual workshop for new health office staff. This three-day workshop provides training on hearing and vision screening, managing children with chronic health conditions in the school setting, guidance for writing emergency management and 504 plans, being a part of the Individual Education Plan (IEP) team, and developing IHPs for students. The SHP also provides guidance and consultation to all school nurses, referencing the Manual for School Health Guidelines that includes a matrix of health care procedures permissible in the school setting. The SHP will continue efforts to ensure that sessions offered at the annual School Nurse Leader Collaborative, Spring School Nurse Association Conference, and the Coordinated School Health Coalition Conference are: applicable to school health services, support nursing best practice and actively promote the school nurse role in care coordination.

The SHP will continue to partner with school board associations, principals' associations, Missouri's Family and Community Trust, and the MO HealthNet Division to promote access to care via Medicaid enrollment and awareness of FQHCs. The SHP will continue to support professional development opportunities for school health services staff by way of trainings, workshops, webinars and regional conferences to address Medicaid enrollment, Medicaid managed care, and management of chronic and chronic conditions.

The Missouri School Boards' Association (MSBA) leads an initiative to routinely include special services representatives and nurses on schools' emergency planning teams and for schools to consider the nature of disabilities and medical conditions presented by students and staff when creating, reviewing, and practicing emergency response plans. The SHP will continue to engage and partner with MSBA on the emergency planning process for students with special needs. The SHP will encourage the utilization of MSBA's Emergency Planning for Students with Special Needs Task Force file of resources to inform and support districts in improving their emergency planning process by considering the unique needs of each person within the school community.

Newborn Screening

Since April of 2017, information about the importance of a medical home for children with and without special health care needs has been included in the Newborn Screening booklet and will continue to be distributed to new and expectant parents. The Newborn Screening booklet is distributed upon request to birthing hospitals, pediatric hospitals, LPHAs, WIC clinics, health care providers, high schools, home birthing centers, midwives, prenatal classes, pediatric clinics, obstetrician and gynecological clinics, businesses, and neonatal intensive care units. On average, approximately 4,000 booklets are requested by these entities per month. In addition, the Newborn

Screening Program will implement a revised parent survey using a new electronic format. The revised survey will continue to include questions about the medical home in order to provide insight into parents' definitions of their child's medical home. In addition, the survey will be distributed to a larger sample of parents with the hope of receiving an improved response rate.

The Missouri Newborn Hearing Screening Program (MNHSP) will continue to collaborate with the Family Partnership to engage families in the Missouri Early Hearing Detection and Intervention (EHDI) system. Family Partners who are parents of children who are deaf or hard-of-hearing will contact parents of newborns who failed the newborn hearing screening to provide parent-to-parent support, review resources, and encourage appropriate follow-up with the medical home. Additionally, Family Partners will continue to emphasize the role of the medical home in management of the unique needs of an infant with hearing loss through distribution of the "EHDI Parent Resource Toolkit for Western Missouri."

Local Public Health Agencies (LPHA)

The MCH Services Program will continue contracts with the LPHAs to support a leadership role for LPHAs at the local level to:

- Build community-based systems and expand the resources those systems can use to respond to priority MCH issues;
- Provide and assure mothers and children (in particular those with low income or limited access to health services access to quality MCH services;
- Reduce health disparities for women, infants, and children, including those with special health care needs;
- Promote the health of mothers and infants by assuring prenatal, delivery, and postpartum care for low income, at-risk pregnant women; and
- Promote the health of children by providing preventive and primary care services for low-income children.

LPHAs efforts to fulfill the purpose of the MCH Services contract will include activities and services that address the needs of children. One LPHA has selected to work on the priority health issue of children with and without special health care needs to ensure coordinated, comprehensive, and on-going health care services for children, provide education about special health care needs, and promote the medical home approach. In coordination with the WIC Program, the Tri-County Health Department will assess the medical home status of children ages 0-5 years. The health department has implemented an electronic health record to maintain accessible, comprehensive, and complete health records that can be shared with other providers. They plan to train providers and those in the community on the medical home approach and increase the number of children and families that have a "care notebook" to assist families and caregivers in maintaining a record of their child's care, services, and providers, which can be taken to all medical appointments, therapies, conferences, and vacations.

State Agencies and Partners

The overall goal of the Missouri Disability and Health Collaborative is to support individuals with intellectual disabilities to be included and have access to the full range of evidence-based physical activity and nutrition programs provided through public health programs. Through the Missouri Disability and Health Collaborative, the DHSS-Bureau of Community Health and Wellness will continue to contract with University of Missouri Kansas City Institute for Human Development (UMKC-IHD) to assist with reviewing and adapting existing nutrition and physical activity strategies to assure inclusivity of people of all abilities. Missouri has developed several strategies to increase access to healthy foods and safe places to be physically active. However, few of these strategies have been designed to be accessible to people with intellectual disabilities or with the specific health needs of people with intellectual disabilities in mind.

In addition to the programs at the DHSS, there are several initiatives that contribute to Missourians receiving coordinated, comprehensive, and ongoing health care services throughout the state. In October 2011, the Centers for Medicare and Medicaid Services (CMS) approved Missouri's State Plan Amendment (SPA) establishing Medicaid reimbursement for health homes, making Missouri the first state in the nation to have an approved SPA for health home services. This first SPA established Community Mental Health Center (CMHC) Healthcare Homes serving individuals with serious mental illness. A companion SPA establishing Primary Care Health Homes (PCHH) in Missouri was approved in December 2011. Both SPAs were effective January 1, 2012. MO HealthNet, the DMH, and the community mental health systems collaborated to establish 'health homes' throughout the state's 29 CMHCs. Missouri's CMHC Healthcare Home Program was selected to receive the American Psychiatric Association's 2015 Gold Achievement Award in the category of community-based programs. The PCHH initiative provides intensive care coordination and care management as well as addresses social determinants of health for medically complex individuals. One aspect of PCHH includes the implementation and evaluation of the Patient Centered Medical Home (PCMH) model. PCHH emphasizes the integration of primary and behavioral health care in order to improve health outcomes. In addition, MO HealthNet employs Registered Nurse Case Managers in the Evidence-Based Decision Support Unit. The Unit established a pilot case management project made up of a multidisciplinary team that includes clinicians. The purpose of the pilot is to build infrastructure to support participants. Participants are selected for the pilot by utilizing an algorithm that determines participants with high needs and expenditures. The initiative builds a collaborative resource network to identify available resources. Care plans are developed for each of the participants in the case management program. Missouri's pediatric hospitals also provide services that support comprehensive, coordinated, and ongoing healthcare. The Journey's Program at the University of Missouri's Children's Hospital helps coordinate care provided by a child's health care professionals, community, and family to meet the physical, emotional, and spiritual needs of the child and family as they cope with complex medical conditions. Children's Mercy Hospital in Kansas City and St. Louis Children's Hospital provide similar services, such as Family Centered Care Coordinators, The Beacon Program and Clinic, and the Pediatric Advanced Care Team.

Childhood Lead Poisoning Prevention Program (CLPPP) staff will continue to work with LPHAs and Mo HealthNet lead case managers to coordinate clinical and environmental services for families of children with elevated blood lead (EBL) levels in order to strengthen the role of primary care providers within the public health domain. Supporting public health relationships involving professionals with a variety of clinical and environmental expertise results in (elevated) children's blood lead levels declining more rapidly, therefore preventing further undesirable health effects. These supportive activities will include:

- Leading education to health care providers, LPHAs, WIC programs, and many community activities;
- Documenting case managers, physicians, and other clinicians names and phone numbers in the records of children with EBL;
- Including Family Partners and representatives of various clinical and environmental disciplines when designing and planning new program strategies;
- Strategies to share and document pertinent case management information and actions across the disciplines and with family/caregiver input to result in coordination of care and more effective, efficient care; and
- Working with Family Partners to review program materials and planned activities.

The CLPPP will partner with other Title V MCH programs, health care providers, and the DESE to establish well-coordinated efforts to provide early evaluation and referrals for services as well as ongoing monitoring and services for children with lead poisoning. Schools should have an early and ongoing role in the appropriate and timely follow-up of children with a history of EBL. Schools can request, collect, and record EBL information for all children in their district. Therefore, increasing timely referrals to the DESE allows children with a history of EBL to access a variety of expanded and ongoing evaluation, monitoring, and intervention services such as school nurses, Parents as Teachers (PAT), First Steps Early Intervention Programs, Head Start Programs, and other special services to develop

IEPs. DESE program staff can provide lead awareness education for all families/children in their districts, from birth to high school graduation, regarding the potential adverse effects of lead on the developing infant and child. They can also share information on services available to families and children to decrease the potential ongoing exposure and detrimental effects of lead. They can work with children's medical providers to assure that initial and ongoing health, developmental, behavioral, and cognitive assessments/evaluations are performed. They can perform or refer for various types of child health and developmental evaluations and intervention services needed due to lead exposures that occur prior to and during their school years.

CLPPP staff will focus on lead hazard reduction in dwellings linked to a child with EBL, including contracting with a licensed lead abatement firm, in compliance with procurement processes. The Program will assist low-income homeowners and landlords of subsidized housing to perform lead hazard reduction in dwellings linked to a child with EBL. Funding will be used to supplement training costs to encourage contractors to become licensed in lead abatement in areas lacking capacity. A recent national study shows that every dollar spent on lead hazard reduction has a \$17 - \$250 return on investment over the life of a child.

The Missouri WIC program will continue to offer training and support to local agencies and community partners interested in implementing the WIC Developmental Milestones Program. Participating agencies will use a set of age-appropriate developmental checklists, based on the LTSAE campaign, to increase parents' awareness of developmental milestones and to promote the early identification of potential developmental delays. Local agencies will refer participants for screening and early intervention services to primary care physicians or Individuals with Disabilities Education Act (IDEA) diagnostics programs, known in Missouri as First Steps (0-3 years of age) and Early Childhood Special Education (3-5 years). Local agencies may also refer their participants to ParentLink, an affiliate of Help Me Grow National Center, for validated screening and connection to intervention programs. Data reports from the Missouri WIC Management Information Systems (MIS) on referrals and follow-ups will be available for FFY 2023. These reports will be used to assess the program's effectiveness in providing referrals and access to early intervention programs. Technical assistance from DHSS will be available to all current participating agencies to improve program effectiveness.

The DHSS will support participating entities by providing education and promotional items, including printed materials such as the developmental checklists and the Amazing Me books developed by the CDC. The Missouri WIC program will consider promotional materials that will assist parents in assessing their child's development such as feeding utensils. These resources will be available for WIC agencies as well as internal and external stakeholders as part of providing educational support and promotion of early identification of potential developmental delays. Monthly updates on various child development topics will be posted on the Missouri WIC webpage to provide education and support to local agencies.

Efforts by the Missouri WIC program to recruit non-participating local agencies and external partners to implement the WIC Developmental Milestones Program will continue. Training and support will be provided to local agencies interested in implementing the program, including the language component, *Talking is Teaching: Talk, Read, Sing*. Implementation training developed by the CDC will be used to onboard new local agencies enrolling in the program. Agencies will also be required to complete the Association of Public Health Nutritionist (ASPHN) "Introduction to Child Development" training for WIC staff. The Missouri WIC Facebook page will host monthly posts to promote the program to local agencies and the public. Results from a FY21 local agency survey will be used to determine current program participation rates, clinic activities, and training needs from participating agencies as well as gather data on program interest from agencies not currently enrolled. Feedback from agencies not currently enrolled will be used to design future promotional activities. DHSS will continue to collaborate with local and nationwide partners to promote developmental milestones and identification of educational resources for parents and health care providers. Collaborations with CDC, ASPHN, ParentLink, and Wichealth will continue.

Other Title V MCH Activities Related to cyshcn

SHCN coordinates programs and initiatives focused on developing, promoting, and supporting community-based systems that enable the best possible health and greatest degree of independence for Missourians with special health care needs. SHCN accomplishes its mission in collaboration with families, health care providers, and other community, state, and national partners. SHCN values family partnerships in decision-making and satisfaction with the services they receive. SHCN programs and initiatives include the ABI Program, Brain Injury Waiver (BIW) Program, CYSHCN Program, HCY Program, Family Partnership Initiative, and MFAW Program. Bureau programs and initiatives that serve cyshcn include the CYSHCN Program, the HCY Program, and the Family Partnership Initiative. In addition to these programs and initiatives, SHCN provides funding to Missouri Assistive Technology for the Kids Assistive Technology (KAT) project, which improves access and reduces barriers for cyshcn. SHCN also facilitates the Missouri Brain Injury Advisory Council and administers the Federal Traumatic Brain Injury State Partnership Grant.

The CYSHCN Program provides statewide assistance for individuals from birth to age 21 who have or are at increased risk for a medical condition that may hinder their normal physical growth and development and who require more medical services than children and youth generally. The program focuses on early identification and service coordination for individuals who meet medical eligibility guidelines. As payer of last resort, the CYSHCN Program provides limited funding for medically necessary diagnostic and treatment services for individuals whose families also meet financial eligibility guidelines. To be eligible for the CYSHCN Program, participants must: be a Missouri resident, be between birth to 21, have an eligible special health care need (conditions such as cerebral palsy, cystic fibrosis, cleft lip and palate, hearing disorders, hemophilia, paraplegia, quadriplegia, seizures, spina bifida, and traumatic brain injury), and meet financial eligibility guidelines for funded services (family income at or below 185% of the Federal Poverty Guidelines). The CYSHCN Program provides two primary services: Service Coordination and Funded Services. Service coordination is provided to all participants, regardless of financial status, including: outreach/identification and referral/application, eligibility determination, assessment of needs, resource identification, referral and access, family support, service plan development and implementation, monitoring, and evaluation, and transition/closure. SHCN maintains contracts with multiple LPHAs to provide service coordination for the CYSHCN Program. CYSHCN Service Coordinators complete comprehensive individual assessments during annual home visits to identify each participant's/family's unique needs and assist the family with resource identification and referral to ensure their needs are met. In addition to service coordination, limited funding (up to \$25,000 annually per participant) is available for medically necessary diagnostic and treatment services for participants whose families meet financial eligibility guidelines. Funded services may include but are not limited to: doctor visits, emergency care, inpatient hospitalization, outpatient surgery, prescription medication, diagnostic testing, orthodontia and prosthodontia (cleft lip/palate only), therapy (physical, occupational, speech, and respiratory), durable medical equipment, orthotics, hearing aids, specialized formula, and incontinence supplies. Service Coordinators assist participants/families with resource identification and referral. All third party liability is exhausted prior to accessing CYSHCN program funds. Direct care diagnostic and treatment services are supported through state funds. Service coordination is supported through state funds, Medicaid, and MCH Title V Block Grant.

SHCN administers the HCY Program through a cooperative agreement with MO HealthNet. To be eligible for the HCY Program, participants must be a Missouri resident, be between birth and 21 years, need medically necessary services, and be enrolled in the MO HealthNet fee for service system (not the MO HealthNet Managed Care Plans). The HCY Program provides service coordination that involves: evaluation and needs assessment, identifying and accessing service providers, service plan development and implementation, coordination of services through resource identification and referral, family support, assisting in establishing a medical home, transition planning, and

prior authorization of medically necessary services (private duty nursing, advanced personal care, personal care aide, skilled nursing visits, authorized registered nurse visits, and administrative case management). SHCN Nurse Service Coordinators monitor services through assessments, regular home visits, medical records, and care plan review. The HCY Program is primarily supported through Medicaid funds with secondary support through state and Title V MCH Block Grant funding.

The SHCN Family Partnership enhances the lives of individuals and families impacted by special health care needs by providing resources and information to empower families to live a good life. The Family Partnership hosts events to benefit families through development of leadership skills, networking among peers, and staying current with trends and issues regarding special health care needs. Each Family Partner is a parent of a child or youth with special health care needs and is well equipped to help families explore options and solutions. The SHCN Family Partnership is funded primarily through the Title V MCH Block Grant and secondarily through the HRSA Universal Newborn Hearing Screening and Intervention Program Grant. Additional information about the SHCN Family Partnership can be found in the Family Partnership section of the grant application.

Cross-Cutting/Systems Building

State Performance Measures

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator	0		48
Numerator			
Denominator			
Data Source	MO DHSS MCH Program training attendance sheets		MO DHSS Internal Survey
Data Source Year	2019		2021
Provisional or Final ?	Provisional		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	100.0	150.0	175.0	200.0

State Action Plan Table

State Action Plan Table (Missouri) - Cross-Cutting/Systems Building - Entry 1

Priority Need

Address Social Determinants of Health Inequities.

SPM

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Objectives

Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Strategies

Ensure culturally and linguistically appropriate resources, education, and care are available for all women of childbearing age, mothers, children, and adolescents, including children and youth with special health care needs, and their families.

Promote breastfeeding in a culturally appropriate manner.

Educate DHSS Title V partners on the medical home approach and definition of children and youth with special health care needs.

Encourage and employ person-centered approaches to Title V programming.

Operationalize core MCH values, establish a standard level of training on the MCH Leadership Competencies, and create a plan to implement training to all Title V funded partners.

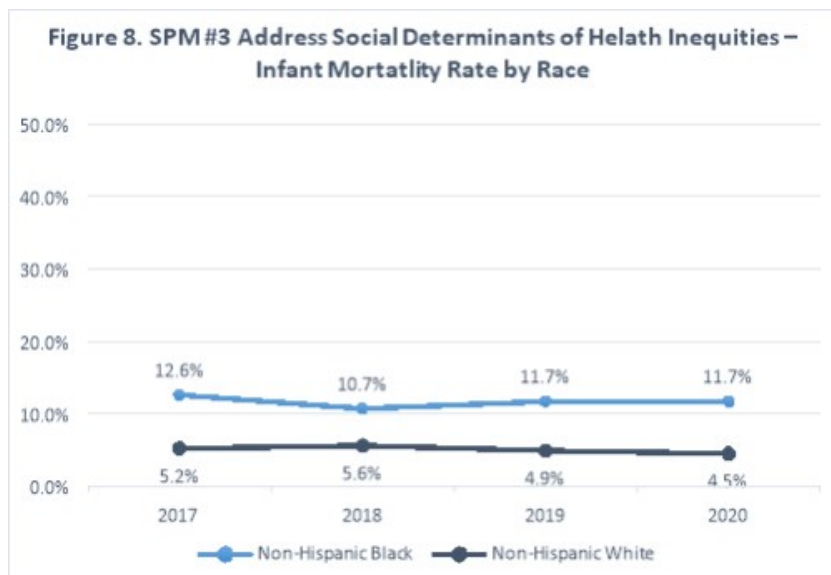
Build program and policy evaluation capacity.

SPM #3 Address Social Determinants of Health Inequities.

Please note that additional examples of how SDoH were addressed may be found throughout the annual report narratives for the other National and State Performance Measures by population domain.

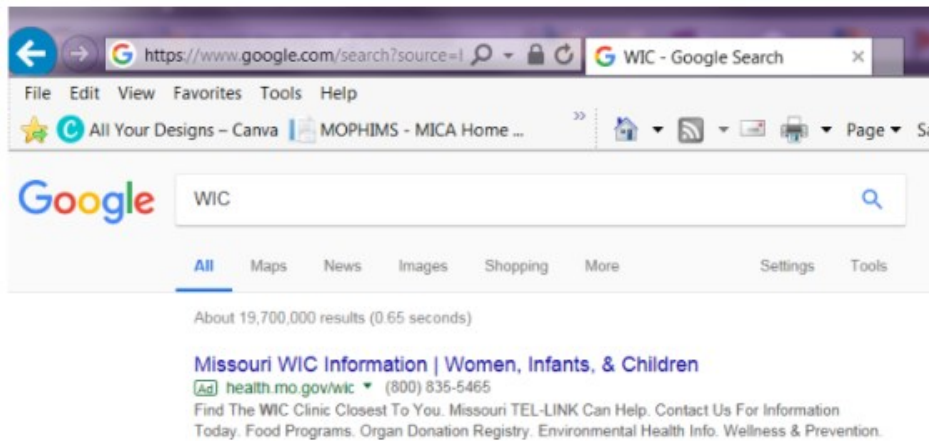
Existing economic and health disparities indicate a continuing need for prioritizing health equity efforts. Economic stability is one of the primary social determinants of health (SDoH). Missouri's poverty rate has declined each year from 14.8% in 2015 to 12.9% in 2019¹, which suggests increasing economic stability for some Missourians. However, additional examination indicates that poverty is consistently higher among Non-Hispanic Blacks and Hispanics compared to Non-Hispanic Whites. In 2019, the poverty rate for Non-Hispanic White Missourians (11.4%) was lower than that of both Non-Hispanic Blacks (21.2%) and Hispanics (20.5%).¹ Geographic disparities in poverty also exist with a 10.8% poverty rate for urban counties in 2020 compared to a 14.5% poverty rate for the rural counties in the same year.²

Health care access and quality is also a primary domain of SDoH. Racial disparities in both infant and maternal mortality indicate a need to explore improvements in health care access and quality as part of health equity efforts. Missouri Vital Statistics data denote the Missouri infant mortality rate for 2020 was 5.7 per 1,000 live births, capturing the 392 infant deaths for that same year. Though there was a reduction in Missouri's overall infant mortality rate from 2019 to 2020, the racial disparity between Non-Hispanic Black women and Non-Hispanic White women persisted (Figure 8). Additionally, the 2016-2020 maternal mortality rate for Non-Hispanic Black women (80.6) was considerably higher than that of Non-Hispanic White women (30.6).



The TEL-LINK Program referred 344 callers to health insurance providers and 268 callers to non-emergency medical transportation services to increase access to health care and insurance coverage. TEL-LINK responds to all Missourians regardless of income, gender or geographic location. The Program also provides referrals to individuals facing homelessness and links them with food assistance and shelter resources in their local communities. TEL-LINK provided outreach to the underserved population through effective marketing strategies. In FY21, the Program created a search engine campaign (*See screenshot image below.*), which was displayed to 148,706 Missourians. During the campaign, 8,414 participants clicked on the ad and were directly connected with a

TEL-LINK operator who connected them with local resources. The campaign was set up using relevant search terms and ads. When individuals Googled key search words (example below), the results provided a click-to-call (mobile only) ad, allowing customers to call TEL-LINK with a single click.



The MCH Services Program continued to contract with LPHAs who were working to address SDoH and health inequities within the MCH population. Specifically, these contractors are the LPHAs used the Life Course Perspective as a framework to increase protective factors and reduce risk factors—inherently increasing health equity. Some LPHAs collaborated with schools to have a mental health provider on-site, so that mental wellness services were accessible to all Students. In addition, some LPHAs collaborated with oral health providers to provide a mobile dental unit on site at the health department and/or school to make oral health services accessible. Some communities reported seeing increased use of telehealth services as well as mobile units to provide behavioral, dental, and/or medical health care services.

The Pregnancy Associated Mortality Review (PAMR) abstractor included information related to SDoH, such as lack of transportation, inadequate insurance coverage and travel distance to the nearest medical facility, in case narratives to encourage the development of recommendations addressing these SDoH. The expected impact level was documented for each recommendation and was ranked from small (community and/or provider-based health promotion and education activities) to giant (poverty, inequality, etc.) impacts. In addition to the information provided by the abstractor, the PAMR Analyst created a "Community Dashboard" which utilized a number of datasets looking at a variety of factors related to the geographic area of residence. Examples included birth outcomes, built environment, and socioeconomic indicators. Further development of the Dashboard was hindered due to staff being redirected to focus on the state's response to the COVID-19 pandemic, but the Dashboard continued to be a priority, and PAMR staff worked with partners at the Centers for Disease Control and Prevention (CDC) and Emory University to continue to develop the Dashboard. PAMR recommendations in the annual maternal mortality report are shared broadly among stakeholders including the Missouri Legislature, LPHAs, hospitals, community-based organizations, and many other listserv distribution lists. Following the release of the 2021 maternal mortality report, the PAMR Coordinator and program staff completed 20 different dissemination activities to ensure broad dissemination of the PAMR recommendations. From 2020-2021, the Missouri Hospital Association (MHA) implemented the Alliance for Innovation on Maternal Mortality (AIM) Severe Hypertension in Pregnancy bundle as a result of cardiovascular disease in pregnancy (including preeclampsia) being a leading cause of pregnancy-related mortality, utilizing PAMR data as the source. The Severe Hypertension in Pregnancy patient safety bundle has been revised to incorporate Respectful Care elements throughout the bundle to ensure whole person, patient-centered, and trauma-informed care for every patient, in every clinical encounter.

The Missouri Women, Infants, and Children (WIC) Program promoted the importance of depression screening utilizing the Patient Health Questionnaire-2 (PHQ-2) for prenatal, breastfeeding, and non-breastfeeding woman. The purpose of the PHQ-2 is not to establish a final diagnosis or to monitor depression severity, but rather to screen for depression in a “first step” approach. WIC continued the referral system to the Home Visiting Program, TEL-LINK, the Missouri Primary Care Association, and other support programs. WIC continued outreach efforts to enroll prenatal women in the WIC Program in their first trimester.

The Missouri WIC Program continued to promote and offer the Missouri WIC Developmental Milestones Program (accessible [here](#)) at WIC local agencies statewide. The Program, based on the CDC LTSAE public health campaign, assisted participating agencies with monitoring children’s developmental milestones and knowing when and how to refer families for follow-up if there were concerns. The Program uses a set of checklists and family-friendly wall and floor graphics to increase parents’ awareness of developmental milestones and to promote early identification of potential developmental delays.

The Missouri Department of Health and Senior Services (DHSS) Newborn Hearing Screening Program (NHSP) provided summary lost-to-follow-up data and assisted an audiology clinic determine regions in which to target their mobile services. The mobile unit provided patients who would not otherwise have access to pediatric audiology services with an option close to home. Family Partners shared contact and scheduling information with families of infants and children from birth to 21 years old who required audiologic follow-up after failed or missed hearing screenings, or when hearing concerns were noted. As of September 2021, midwives obtained the ability to enter newborn hearing screening results directly into the NHSP data management system, eliminating the need for mailing/faxing paper forms. This has increased NHSP follow-up of infants screened for hearing loss following a home birth.

The Office of Dental Health (ODH) targeted the MCH population to promote the benefits of oral health throughout the lifespan. One of the primary areas of focus was the importance of water fluoridation. ODH coordinated a Community Water Fluoridation media campaign that was published in about 20 newspapers and reached approximately 217,000 households. The newspaper campaign was an easy to read flyer showing the benefits of water fluoridation. Additionally, there was a 30-second radio public service announcements (PSA) highlighting the benefits, safety and equity of water fluoridation. The PSA was broadcast in 30 counties. ODH also provided oral health information and supplies, including toothbrushes, toothpaste, floss, and fluoride varnish, to the Office of Minority Health to distribute during events targeting minority populations in underserved communities. Although attendees included families, the events were specifically targeted towards children. Oral care information and supplies were given to 471 households, representing nearly 2,000 Missourians.

The DHSS Newborn Screening Program collaborated with midwives across the state to ensure uninsured and low income clients had access to affordable blood spot screening. The Missouri State Public Health Laboratory maintains agreements with approximately 40 midwives primarily caring for clients who otherwise would decline blood spot screening due to cost. The midwives were able to purchase blood spot collection cards at a discounted rate and pass those savings on to qualifying clients. Midwives serving this population reported an increase in compliance and fewer refusals due to the more affordable cost.

The Section for Women’s Health (SWH) participated in the Missouri Rights of Victims of Sexual Assault Taskforce. This Taskforce identified areas for action to improve the rights of survivors of violence. By working with partners across disciplines, the SWH was able to engage in strategic planning and action to improve health care equity. Highlights of the work accomplished included recommendations that prioritized: promoting the long-term health of female adult survivors, including testing and prophylaxis for sexually transmitted infections, improved access to care for survivors across regardless of geographical location, and increasing trauma-informed care. The final report can

accessed [here](#).

The Bureau of Special Health Care Needs (SHCN) Service Coordinators and Family Partners continually focus on the SDoH for families of individuals with special health care needs served by SHCN. SHCN employs Family Partners to provide the unique perspective of parents of individuals with special health care needs. Interpreters are utilized for conversations, and forms are translated into various languages, including Arabic, Bosnian, Burmese, French, Russian, Somali, Spanish, and Vietnamese. The Service Coordination Assessment (SCA) is a comprehensive assessment that includes assessing, identifying, and addressing concerns beyond the scope of services provided through SHCN programs. Examples of topics covered in the SCA include, but are not limited to: insurance coverage, military service, mobility, transportation, dietary concerns, emotional status, social/environmental barriers (such as social inactivity and barriers keeping the participant from getting out into the community or participating in activities they enjoy as well as home environment safety and stability of living conditions), cognitive concerns, educational/vocational history and aspirations, family functioning (such as risk factors and family support), and cultural belief system. SHCN Service Coordinators and Family Partners frequently connect families with resources for food, housing, utility services, social supports, transportation, and recreational/leisure opportunities. SHCN emphasizes improving the quality of life for participants and families beyond the direct care services provided through SHCN programs. Additional information regarding SHCN is included in the CSHCN Domain of the application and report.

The Bureau of Environmental Epidemiology (BEE) Childhood Lead Poisoning Prevention Program (CLPPP) is a participating member of the St. Louis Health Homes and Energy Efficiency Coalition. The Coalition is working to establish a local system for referring families to various service providing entities by using a universal needs survey. Additionally, CLPPP increased the number and quality of partnerships with an array of health partners providing services across the state. This collaborative system will enhance the Program's ability to address SDoH contributing to maternal and child lead exposure and treatment and lead mitigation.

The Bureau of Community Health and Wellness (BCHW), which includes the School Health, Injury Prevention, Adolescent Health, Tobacco Control and Prevention, and Nutrition and Physical Activity programs, addressed SDoH as a strategy to reduce health disparities. For example, the School Health Program (SHP) provided support and resources to school nurses across the state to assist families with health insurance and health referrals to increase access to care. The Tobacco Prevention and Control Program worked to increase access to smoking cessation services. In the past year, the Program expanded Missouri Quit Services to youth as young as 13 years. This Program also has an enhanced coaching package for pregnant women and requires materials and coaching services be available for specific high-risk populations. Additional examples of activities included:

- When identifying communities for funding opportunities, BCHW included social determinants (for example graduation and poverty rates) as variables.
- BCHW encouraged, and in some cases required, coalitions to engage members of the population being served to ensure their voices were heard. Where possible, programs encouraged compensation for these community members to acknowledge the value of their time and input.
- BCHW programs also worked on strategies to address housing and the built environment. For example, the Tobacco Prevention and Control Program assisted low-income multi-unit housing to become smoke and/or tobacco-free.

SDOH impact child health and contribute to health disparities. Given their unique role as school-based clinical experts, care coordinators, and student advocates, school nurses are well suited to serve as leaders in addressing SDOH. School nurses are often the first point of contact for children facing social and emotional barriers to learning because social and emotional needs often present as physical symptoms, such as headaches and stomachaches.

The SHP tracked chronic conditions in K-12 schools to help identify health disparities and root causes (often rooted in SDOH) that contributed to the disparities. For example, the Program identified higher rates of chronic conditions in schools in neighborhoods with lower socioeconomic status (SES). CDC reports indicate on average one in 10 students is likely to have asthma. Some schools in low SES neighborhoods report 22% of their students have asthma. The SHP established a repository for data related to prevalence of asthma in school districts, assisted in the development of an evidence-based intervention designed to assist school nurses in improving asthma outcomes in the school setting, and served as a vital link in the dissemination of information to school nurses across the state. The Data showed school districts with higher rates of asthma corresponded with low income as well as other negative social determinants of health. The average prevalence of asthma was approximately 9% for districts reporting, with the prevalence in some districts as high as 22%. The Missouri Asthma Prevention and Control Program (MAPCP) and its partners utilized this data (along with data from other sources) to focus its efforts in rural regions with the most need (<https://asthmaready.org/regions/>). The SHP assisted in the development, implementation and evaluation of Teaming Up for Asthma Control (https://www.cdc.gov/pcd/issues/2017/17_0003.htm), an evidence-based asthma self-management education program designed for school nurses. This program was implemented for workforce development across the state, specifically in areas with the greatest need. The SHP's strong communication connection with school nurses allowed the MAPCA and SHP to quickly provide asthma education and information through the Missouri Healthy Schools [website](#) and the ECHO [platform](#). This also allowed rapid dissemination of policy changes related to the administration of asthma medications during the COVID-19 pandemic (<https://showmeecho.org/clinics/ace/back-to-school-planning-for-asthma-management-and-covid-19-response/>).

Managing students with chronic conditions helps them achieve the highest possible level of education, which is a significant predictor of health. School nurses provide clinical guidance for addressing the SDOH when caring for children with health problems such as asthma, diabetes, seizures, sickle cell disease, life threatening allergies, and/or mental health challenges and can eliminate or manage health-related barriers to learning by helping keep kids in the classroom. The DHSS School Health website featured the most recent guidance on managing children with chronic health conditions, and the Program hosted webinars with content experts to address hot topics and changes in disease management. The SHP partnered with the DHSS asthma and diabetes programs and organizations such as the Epilepsy Foundation of Missouri and Kansas and the Asthma and Allergy Foundation.

The SHP focused on access to care by hosting webinars led by the managed care health plans and the Legal Aid Society to foster a better understanding of Medicaid managed care plans and Medicaid enrollment. The Program used the School Nurse Link [website](#) to ensure school nurses received timely communication regarding resources for families about managed care plans.

In 2020, the SHP piloted The School Nurse: Chronic Health Assessment Tool (SN CHAT), developed to help school nurses gather information from parents. By using this tool, school nurses were able to ask essential and probing questions to gain insight into the health needs of the individual student with a chronic health condition or special health care need, such as health insurance, access to affordable care and/or transportation. The goal was to foster a stronger relationship with the parent and develop a plan to permit full inclusion in school and school-related activities. Feedback from school nurses regarding using the tool when communicating with parents included increased parent engagement, "parents feel their voice is heard", the tool was easy to use, and the tool "was a 'game changer'". The SHP co-presented regarding the shared role of a pediatrician and school nurse on the Kids and COVID ECHO, the annual school nurse conference and the coordinated school health conference. Evaluations from the three sessions were positive with numerous comments on intent to use the tool in school nurse practice and/or with other school nurses. The Program used SN CHAT in seven school districts participating in a chronic disease management CDC grant. The overall number of students with a chronic health condition receiving care coordination, as evidenced by having an emergency action care plan in place, and having health insurance increased from 39% to 80%.

Additionally, 3,158 school health staff received training related to caring for children with chronic health conditions.

The Child Care Health Consultation (CCHC) Program provided consultation and training to child care providers and health promotions for children in child care and their families at both regulated and unregulated child care facilities, including those that serve families eligible for the Child Care Subsidy Program. The CCHC Program provided services to adults and children of all abilities. Services also addressed a variety of health and safety topics that affect SDoH, and services were provided at little or no cost to the child care provider and the children in their care to ensure that child care providers and children in child care at all types of child care facilities had access to program services. CCHC trainings assisted child care providers in identifying and utilizing resources and organizations available in their communities to help address social determinants of health inequities. Examples of these included, but were not limited to: free educational materials that promoted physical activity and nutrition, free educational materials regarding the Safe to Sleep campaign, obtaining and using free developmental screening tools, early intervention programs, and positive behavior support strategies to reduce the expulsion/removal of children from child care environments. The CCHC Program also provided consultation to child care providers to assist in the development of individualized care plans and completion of referrals to outside resources such as MO HealthNet for Kids, developmental screening, and WIC. By offering these services, more families received education about resources available to them and more children had access to health care and proper nutrition. Child care providers became more knowledgeable about services available within their communities and were better equipped to make referrals. The CCHC Program Manager continued to assist LPHA staff in the development of resources for consultation and training for child care providers and families and health promotions for children in child care that address social determinants of health inequities. The CCHC Program encouraged family participation in all program services. The capacity of LPHAs to deliver CCHC services was severely impacted by the ongoing COVID-19 pandemic.

The Department of Elementary and Secondary Education (DESE) Office of Childhood is developing an early childhood system that is family-friendly and ensures every young child receives services needed. Building from work of the Early Childhood Comprehensive System (ECCS) previously led by the DHSS, the OOC began development of an Early Childhood Integrated Data System, a virtual hub for all families with children ages 0-5, and regional hubs across the state. The “ECCS Health Integration: Prenatal to 3 Program” grant was awarded to Missouri in August 2021. Through this grant, the ECCS Program began leading integration of health needs, resources, and systems into the existing Statewide Early Care and Education (ECE) Strategic Plan and building on existing collaborative efforts to increase the impact for the prenatal to three population.

Prior to the consolidation of early childhood programs into the OOC in August 2021, the Parent Advisory Council (PAC) was housed in the DHSS and provided mini grants to PAC members and community partners to provide training on the 5 Protective Factors to the Father Cafés. The PAC was also in the early stages of partnering with the “If I Need Help” Program”, a program that helps loved ones who are lost, disoriented or cannot self-advocate with their loved ones and caregivers. Staffing vacancies before and after and reprioritization after the transition to the OOC interrupted these efforts and limited progress.

The OOC Quality Initiatives Section provides inclusion referral services, technical assistance, and training throughout the state to help families and caregivers of children with special needs in licensed, regulated or registered child care settings across the state regardless of income or location. The OOC contracted with United 4 Children to provide inclusion services to support children with special needs, including children with a perceived developmental disability and/or delay, health/mental health, and/or behavior issues. Inclusion Specialists assisted families in locating appropriate child care to successfully support the individual needs of each child and connect the families with other community resources as appropriate. The Inclusion Specialists provided technical assistance, training, and

strategies to support the child with special needs to increase their retention in the child care setting. Specialists helped child care providers identify social determinants such as housing, food access, poverty, or exposure to violence as possible reasons behind children's behaviors. Child care provider knowledge and skills increased regarding how to better work with and maintain care for children with special needs, resulting in increased incidence of appropriate child care placement and decreased incidence of expulsion from child care. The quantity of inclusion technical assistance and trainings to child care providers decreased due to impacts of the COVID-19 pandemic.

The Home Visiting Program in the Office of Childhood includes the following contractual deliverable in every Title V MCH funded contract, "*The Contractor shall, to the extent possible, ensure supervisors and home visitors reflect the ethnic, cultural, and social characteristics of the community served through this contract.*" The Home Visiting Program contracts include this language to ensure that families are a part of the program rather than a recipient. The level of trust and rapport necessary to successfully support a family through home visiting is enhanced by having contracted home visiting staff who reflect the characteristics of the community they serve. The Home Visiting Program shared resources for home visiting staff through a variety of ongoing communication including: postings within the Continuous Quality Improvement Missouri Home Visiting Gateway Website, located on the Home Visiting Program's web-based data collection system platform; the Weekly Update emailed to each contracted home visitor and supervisor, the monthly subrecipient monitoring calls with contracted agencies, and during annual home visiting professional development events.

The Safe Cribs for Missouri Program in the OOC participates as a member of the Missouri Safe Sleep Coalition. The Coalition's Missouri Safe Sleep Strategic Plan, developed with guidance from the National Institute for Children's Health Quality, includes Health Equity/Reducing Disparities as one of the five core focus areas. The Health Equity/Reducing Disparities core focus area includes addressing multiple barriers, systemic disparities, SDoH, and cultural norms that prevent adherence to safe sleep and focusing on SDoH as a priority in community outreach.

To address the SDoH inequities and continue building a comprehensive maternal-child public health system to address the priority needs of Missouri's MCH population, the MCH Director:

- Used web-based platforms to engage in virtual meetings and continue to build relationships with statewide MCH stakeholders;
- Provided virtual and in-person presentations on the Life Course Perspective and facilitated a simulation of the Life Course Perspective for students enrolled in a MCH-focused MPH graduate program;
- Initiated and engaged in discussions related to the SDoH, health equity, justice, diversity, and inclusion with internal and external MCH partners and stakeholders;
- Participated as a panelist for the Missouri Health Equity Advisory Committee;
- Promoted activities and initiatives to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities; and
- Practiced, promoted and supported efforts to recruit and retain a qualified, diverse and well-trained MCH workforce.

¹ U.S. Census Bureau, American Community Survey 1-Year Estimates Subject Tables

² U.S. Census Bureau, Small Area Income and Poverty Estimates (SAIPE).

SPM #3 Address Social Determinants of Health Inequities.

The Centers for Disease Control and Prevention (CDC) defines Social Determinants of Health (SDoH) as “conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes.” SDoH include factors like socioeconomic status, education, neighborhood and physical environment, employment, social supports, and access to quality health care. From the Life Course Perspective, addressing SDoH is integral to improving health and reducing longstanding disparities in MCH. Many disparate health outcomes persist in MCH, including a higher risk of maternal mortality among Black women and a higher risk of infant mortality among Black infants. A deeper understanding of SDoH and the root causes of health inequities is imperative for promoting and improving the health of Missouri’s mothers, infants and children.

To gain buy-in and build internal awareness and understanding across MCH programs and the Department of Health and Senior Services (DHSS) overall, the Title V Program is developing a core MCH, health equity, and social justice training plan, including didactic and interactive experiences for leaders, team members and MCH program staff. To gain a better understanding of the impact of SDOH and how to effectively integrate strategies to address the root causes of health inequities into policies and program services and activities and to provide foundational skills, Title V Program leadership is working to identify workforce development training on MCH fundamentals, SDoH, health equity, and social justice. The Title V MCH team is reviewing existing resources, MCH Navigator trainings, MCH Leadership Competencies, and evidence-based training methods and content and developing a continuously evolving training plan to establish initial and ongoing training requirements for internal Title V MCH Block Grant-funded program staff and external contractors. The training plan will continue to be developed and implemented beyond the Title V Core Team.

In alignment with the new DHSS *Culturally and Linguistically Appropriate Services Standards* Policy, the diverse populations served by Title V will be considered at all stages of Title V program and service delivery, and Title V funded MCH programs will consider the needs of their target population(s) and how programs will be inclusive of and non-stigmatizing towards program participants. All programs and services will be culturally and linguistically aware and appropriate, to provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs. Special focus will be given to marginalized and underrepresented populations and communities. The Culturally and Linguistically Appropriate Services (CLAS) standards will be applied as general guidelines for all programs and services to provide a uniform framework for developing and monitoring CLAS that are broadly inclusive of diverse racial, ethnic, sexual, and other cultural and linguistic groups.

The person-centered approach ultimately sees human beings as having an innate tendency to develop towards their full potential. The key principles of person-centered care include: valuing people – treating them with dignity and respect by being aware of and supporting personal perspectives, values, beliefs and preferences; autonomy - providing choice and respect for choices made; life experience - understanding the importance of a person’s past, their present-day experience, and their hopes for the future; understanding relationships - collaborative relationships, social connectedness and opportunities to engage in meaningful activities; and environment - organization-wide commitment to individual and organizational learning underpinned by person-centered principles. Title V funded MCH programs and services will incorporate the key principles and apply the central themes believed to help achieve person-centered care: 1) congruence – being completely genuine; 2) empathy – striving to understand a person’s experience; and 3) unconditional positive regard – being non-judgmental and valuing.

Information regarding services provided to address the SDoH inequities for children and youth with special health

care needs and their families can be found in the CSHCN Population Domain and Family Partnership section narratives.

With leveraged funding from the CDC SPAN grant, the DHSS will provide a lactation consultant preparation course at a centrally located site, making it available to all areas of the state that currently have low breastfeeding rates and disparities in the care available to women of color. Every effort will be made to encourage women of color to become peer counselors or International Board Certified Lactation Consultants (IBCLCs) in regions where disparities in breastfeeding support exist.

The Missouri Physical Activity and Nutrition (MPAN) Program will continue collaborating with the Healthy Weight Advisory Committee, a subgroup of the Missouri Council for Activity and Nutrition. The Committee provides expertise and advice to advance and monitor collaborative, sustainable, evidence-based strategies for increasing the number of children at a healthy weight. MPAN will support the Advisory Committee in efforts to increase workforce capacity to deliver weight management treatments aligned with the newly available MO HealthNet benefit for children and adults.

The School Health Program (SHP) will continue to implement the School Nurse Chronic Health Assessment Tool (SN CHAT) and broadly promote the resource as a tool for school districts to improve the quality of student health information and plan to appropriately address student health and education needs. Additional information regarding SHP activities to address the SDoH inequities for children and youth with special health care needs and their families can be found in the CSHCN Population Domain narratives.

As administrator of the Early Childhood Comprehensive Systems (ECCS) Health Integration P-3 grant, the DESE Office of Childhood (OOC) will work with a contractor to provide the Safe Environment for Every Kid (SEEK) training to pediatricians and family medicine physicians across the state. The trainings will include strategies to address targeted SDoH that are also risk factors for child maltreatment, such as parental depression, major stress, substance use, domestic violence, food insecurity, and harsh punishment. One goal for this training will be to further inform health providers of the referral process and ensure a safe environment for all children in Missouri. The grant will also be used to provide maternal substance use and trauma training to home visitors and other early childhood care and education professionals.

Other Title V Program Activities Related to the Cross-Cutting & Systems Building Domain

To continue building a comprehensive maternal-child public health system to address the priority needs of Missouri's MCH population, the MCH Director will continue to:

- Build relationships with statewide MCH stakeholders;
- Provide presentations on and facilitate a simulation of the Life Course Perspective to undergraduate and graduate students and internal and external partners and stakeholders;
- Initiate and engage in discussions related to the SDoH, health equity, justice, diversity, and inclusion;
- Participate in the Missouri Health Equity Committee;
- Contribute to Department efforts to create a diverse and inclusive work environment and incorporate the principles of justice, equity, diversity and inclusion into programs and initiatives;
- Promote activities and initiatives to ensure access to care, including adequate insurance coverage, for MCH populations and to promote partnerships with individuals, families, and family-led organizations to ensure family engagement in decision-making, program planning, service delivery, and quality improvement activities;
- Explore opportunities to expand Missouri's MCH data capacity and enhance public health surveillance/reporting systems; and

- Promote and support efforts to recruit and retain a qualified, diverse and well-trained MCH workforce.

The Child Care Health Consultation (CCHC) Program will continue to provide consultation and training for child care providers and health promotions for children in child care at both regulated and unregulated child care facilities, including those that serve families eligible for the Child Care Subsidy Program. CCHC program services will continue to be inclusive to adults and children of all abilities, address a variety of health and safety topics that affect SDoH, and be provided at little to no cost to the child care provider and the children in their care to ensure that all child care providers and children have access to program services to improve their health and and promote safe environments. LPHA staff that provide CCHC will continue to assess for referral needs and assist in referrals for health care access, including Medicaid, MO HealthNet for Kids, developmental screening, and WIC. CCHC program services will also continue to assist child care providers in the identification and utilization of community resources and organizations that address health disparities among child care providers and children in child care. The CCHC Program will also continue to facilitate CPR/First Aid training at little to no cost for child care providers. The CCHC Program Manager will continue to assist LPHA staff providing CCHC in developing resources for child care providers and families and health promotions for children in child care. The resources will address SDoH inequities and social justice, and provide resources for employee and community-based assistance. The CCHC program will continue to encourage family participation in all services, and continue to provide consultation and training for child care providers on developing policies, implementing procedures, and providing trainings that promote inclusivity and optimal family partnerships for the health and safety of children in child care.

The TEL-LINK Program will refer callers to Medicaid/MO HealthNet services to increase insurance coverage. The program will continue to provide outreach to the underserved population through effective marketing strategies.

The Newborn Health program will continue to partner with a wide-variety of community health providers to distribute the *Pregnancy and Beyond* booklet, which contains information about financial resources for pregnant women and children, including MO HealthNet.

The Title V MCH funded Home Visiting Program's contracted home visitors will assess all home visiting clients for insurance status at initial enrollment and periodically throughout enrollment. As need for health care coverage is identified, home visitors will assist clients/families in the Medicaid enrollment process and accessing the Affordable Care Act marketplace by linking clients to their nearest Federally Qualified Health Center (FQHC) to speak with a trained navigator in order to obtain eligibility and enrollment assistance. Annual data on insurance coverage through Medicaid, private, or other insurance will be collected on children and primary caregivers enrolled in-home visiting. Insurance coverage is vital to assuring children can access adequate and equitable preventive health care including well child care. Annual performance measure data will be collected on the percentage of children enrolled in home visiting who receive the last recommended well-child visit based on the America Academy of Pediatrics (AAP) schedule. Data will be analyzed for practices indicating unrecognized racial and/or cultural bias that could result in unintentional healthcare inequity.

The SHP, as a member of the Medicaid Advisory Council, will continue to collaborate and partner with the MO HealthNet Managed Care plans, Department of Social Services (DSS), FQHCs, state agencies and programs, and funding organizations to provide information, tools, and resources to school nurses. These materials will equip school nurses with information about health care plans and services to aid them when assisting parents and families obtain adequate health insurance coverage, and access health care services and health plan benefits. The outreach materials and patient education is available in multiple languages and is reviewed by health literacy professionals to assure the messages are relevant to targeted audiences and communities. The SHP will use data shared by DSS to review the reported number of children enrolled in MO HealthNet/Medicaid annually for trends and comparison to the number of students reported as uninsured from school nurse reporting. With the passage of legislation to expand

Missouri Medicaid eligibility to healthy adults, the SHP will work with school nurses to provide information and resources to support them in assisting families with Medicaid/MO HealthNet enrollment. The SHP will support school nurses in assessing student insurance status and assisting families with MO HealthNet applications and accessing benefits through a variety of training opportunities.

The SHP and the MCH Director will continue to participate in the *Show-Me School-Based Health Alliance* as a partner on the steering committee. This Missouri affiliate of the National School-Based Health Alliance will work with partner organizations and community stakeholders to increase the number of school-based clinics and expand the clinic service offerings. Missouri has seen the number of school based health centers rise from five in 2017 to 106 (not including satellite clinics). The Alliance will also work to enhance access to health care services for all students, students missing school for medical appointments and parents missing work to take students to appointments is a barrier to seeking care.

The SHP will continue to collaborate with school health staff in local education agencies (public, private, parochial, and charter schools) to collect annual reporting utilizing an online database. This system has been in place for over a decade and the information is used to identify trends, facilitate planning of state resources, and ensure up-to-date communication with lead nurses in Missouri schools. The SHP uses the data to monitor staffing of school health services and to identify school districts without designated school health services staff. The Program is then able to offer additional support and technical assistance to assure a minimum level of health services are available. The database also collects district-level data for students with health insurance, and the SHP reviews this data to identify resource and information needs of school nurses. The Program also uses this information as an indicator for reporting to state and local leaders on the status of healthcare access in schools and communities. The SHP will continue to engage school nurses to utilize the reporting system and investigate options to update the database to improve collection, access and data sharing.

The MCH Services Program will support LPHA efforts to:

- Increase the number of clients that receive a risk assessment or screening and referral for Medicaid eligibility;
- Assure that all women of childbearing age receive preconception care services that will enable them to enter pregnancy in optimal health; and
- Develop and promote strategies to increase the proportion of women receiving prenatal care beginning in the first trimester.

LPHAs will continue to:

- Screen clients for MO HealthNet or other insurance coverage;
- Screen for an identified primary care provider;
- Perform pregnancy testing, prenatal education, and OB/GYN referrals as indicated;
- Provide prenatal case management and/or referral for pregnant women;
- Assist pregnant women with Medicaid/MO HealthNet program eligibility and enrollment; and
- Screen clients for an identified dental care provider and provide dental referrals as indicated.

The MCH Services Program and the MCH Director will continue to facilitate collaboration between the DHSS, DSS, and the LPHAs to provide Missouri Eligibility Determination and Enrollment System (MEDES) updates, maintain open and effective interagency communication, promote adequate health insurance coverage, and improve health care access for the MCH population.

In addition, the MCH Services Program will continue to contract with 111 LPHAs to address priority MCH issues in their community. The MCH Services Program has worked with the LPHAs to conduct a focused, local assessment of

MCH priority needs, identifying at least one priority health issue aligned with the FFY 2021-2025 Title V priorities, and developed a five-year, FFY 2022-2026, work plan to address the selected priority health issue(s). The LPHA work plans include evidence-based strategies to address their selected local priority health issues, including addressing SDoH, existing health inequities, and gaps/weaknesses in access to care.

- The Jackson County Health Department has chosen Addressing SDoH inequities among women of childbearing age as their selected priority health issue. The LPHA plans to create and adopt a Policy Action Plan that impacts racial disparities and inequities for their health department and provide evidence-based trainings, curriculums and practices on racial disparities and inequities to internal and external providers and partners.

The Safe Cribs for Missouri Program will continue to ensure culturally and linguistically appropriate resources and educational materials are available to participating agencies for promoting Sudden Infant Death Syndrome (SIDS) prevention and safe sleep environments during initial and follow-up educational sessions provided with crib placements.

The Office on Women's Health (OWH) will promote inclusion and equity across all of its programs. The maternal mortality team and Pregnancy Associated Review (PAMR) Board will review all maternal deaths for contributing SDoH and bias and/or discrimination. Data will be used to identify issues and support recommendations to end bias and discrimination and promote health equity. In the women's health programs, the OWH will ensure materials developed and distributed include evidence-based information to address gaps/weaknesses in access to care and health inequity. The violence prevention team will work across topic areas to promote health equity among community health workers. By addressing health equity and the SDoH, the OWH will prevent violence and reduce maternal mortality.

Newborn screening touches nearly every baby born in Missouri from every socioeconomic status and cultural background. The newborn blood spot screening program will continue to strive to understand the parent's experience with newborn screening by implementing an improved survey process. The parent survey will include questions that assess for various barriers to seeking needed repeat screens or additional testing. The survey will ask for voluntary demographic information to ensure data is gathered from diverse participants. Determining areas of the newborn screening population where access or information is lacking will help improve outreach strategies and enhance capacity to provide more meaningful education to parents. The newborn screening team will continue to seek out and participate in opportunities to further understanding of ways to provide more culturally and linguistically inclusive services to the broadly diverse population affected by newborn blood spot screening.

The Newborn Hearing Screening Program (NHSP) will increase the incorporation of CLAS into the program's mission to assure all babies born in Missouri receive a hearing screening and appropriate follow-up to increase the likelihood that children with hearing loss achieve communication skills. The NHSP and its collaborating partners, the Family Partnership and the Missouri State University MOHear Project, will work together to reflect commitment to diversity and inclusion. The NHSP will support, encourage, and empower families with limited English proficiency, including training new NHSP staff on the use of phone interpretation services, updating imagery on the NHSP website and brochures to reflect diverse populations, ensuring all parent letters are printed in English on one side and Spanish on one side, and collaborating with an outreach program to provide a diversity training workshop for NHSP, Family Partnership, and MOHear staff.

The Childhood Lead Poisoning Prevention Program (CLPPP) will focus on available data analytics to identify gaps in care and disparities in blood lead testing across the state. Once identified, outreach strategies will be

implemented and resources distributed to address disparities on a priority basis. CLPPP will also work with national partners to develop and distribute culturally and linguistically diverse resources related to lead poisoning prevention.

The Office of Dental Health (ODH) will continue to promote inclusion and equity across all programs. Based on responses received from the LPHAs regarding the primary languages of their most frequent clientele, ODH had several pieces of oral health literature translated into seven different languages

The Adolescent Health Program (AHP) is undergoing a strategic planning process and plans to organize future Council for Adolescent and School Health (CASH) activities using SDoH categories. The categories will be used to plan future professional development opportunities and identify areas for growth and ways to organize future efforts for the AHP and CASH.

III.F. Public Input

The Department of Health and Senior Services (DHSS) utilizes various opportunities to seek input from stakeholders, community and family partners, and program participants in program decision-making. MCH assessment data, trends, priorities, performance measures, strategies, and outcomes are regularly presented to stakeholders and Title V MCH implementing partners. The Title V MCH Program engages and solicits input from local public health agencies (LPHAs), community-based organizations, primary care and safety-net providers, and family partners to inform ongoing strategy development and implementation. Input is solicited through individual and group presentations, the DHSS website, webinars, stakeholder convenings, advisory groups, and participation in inter-agency committees and task forces.

Message to Partners for Public Input on Proposed Use of Funds

To solicit public input on the FY 2023 Title V MCH Block Grant application and proposed use of funds (PUF), the PUF document was posted on the DHSS website MCH Block Grant and Public Notice webpages, published in the LPHA weekly newsletter, the *Friday Facts*, and disseminated via email to a diverse group of MCH stakeholders. This included administrators from the 115 LPHAs, healthcare providers, non-profit and other community organizations, other government agencies, community members, Parent Advisory Council members, and family partners.

The MCH Director sent the following email message to over 550 MCH partners statewide.

Dear MCH Stakeholder,

Each year, the Missouri Department of Health and Senior Services (DHSS) receives funds from the Health Resources and Services Administration (HRSA)/Maternal Child Health Bureau (MCHB), in the form of the Title V Maternal and Child Health (MCH) Services Block Grant, to be used to promote and improve the health and well-being of Missouri's pregnant women, mothers, infants, children, adolescents, children and youth with special health care needs (CYSHCN), and their families. The block grant requires the DHSS, as the recipient state MCH agency, to solicit public comments from consumers and partners across the state regarding the application and proposed use of funds for the next federal fiscal year (FFY). As a valued partner of Missouri's Title V MCH Block Grant Program, we value your input and appreciate the diversity of perspective and scope of experience your partnership contributes.

We invite you to review the attached FFY 2023 Proposed Use of Funds document and send us any comments or questions you have for the Department's consideration. In addition to the proposed breakdown and distribution of funds for FFY 2023, the document also provides a general overview of the types of services supported through the block grant, and includes the FFY 2021 – 2025 MCH priorities and overarching principles. The FFY 2023 Proposed Use of Funds may also be accessed at <https://health.mo.gov/information/publicnotices/publiccomment.php>.

Please send your feedback on the proposed use of funds by July 25, 2022 to MCH@health.mo.gov

Please feel free to share the Proposed Use of Funds with other partners serving the MCH population. I encourage you to contact me if you would like to discuss new or expanded opportunities for collaboration.

If you no longer wish to receive DHSS MCH communications, please send notification to the email

and/or postal address listed above or simply reply to this message.

Thank you for participating in this important work, sharing your expertise and serving Missouri's MCH populations.

Warm regards,

Responses, summarized below, were received from a total of six partners, stakeholders and community members.

- "It's a great program with great people, and I REALLY appreciate ALL that YOU do! Excellent transparency and communication! I believe that the proposed health priorities align with the national needs, but I am very impressed with the response to local data for state-level specific health priorities. The budget looks fiscally responsible and makes me proud to be part of MCH - good stewards of the funding! I have no concerns at this time and appreciate the opportunity for input and feedback." (A LPHA team member experienced with the MCH Services contract)
- "I don't know if this is relevant for the document sent to me, but I feel that one thing that would help parents with disabled children is that for single parents the income ratio needs to be addressed. I am a single father. My income supports my son, and I and I feel that a parent should not have to decide between healthcare (also including Medicaid or MO HealthNet spend down) and trying to help the child enjoy life to the fullest. If it wasn't for my parents help I wouldn't have made it through last year. Because of COVID the spend down was temporarily excluded. But if in the future it comes back as high as it was originally I was unable to even buy a decent car to get to and from work as a result and had to resort to borrowing my parents' truck. This is just my specific situation, but I believe there are other parents out there with similar situations. I also believe that if you have a disabled child then the State molds people into relying on the state and not able to get a decent job because it will end up costing them more in the long run. So people turn into freeloaders because they feel they have no choice. Just food for thought." (Single father of a CSHCN)
- "I am actively involved in preventing unintentional injuries in adolescents with the current contract. I know this is not what you were sending inquiries about, but I have a vision for a future contract. We could not have foreseen the formula crisis our country is having, but I would love to see an emphasis on breastfeeding, especially increasing the incidence, outreach to the mothers and babies we serve to at least initiate breastfeeding to reduce mass panic that has surrounded this crisis. I believe it also empowers women to take care of their families in a manner that they can personally take pride and have confidence in. I am aware that not everyone can breastfeed, I do not seek to bully or shame anyone, just to approach it with an open mind and the attitude that "any is better than none" when it comes to breastmilk. If you are not the person who deals with implementation of new topics, please direct me to the one who does so it can hopefully be considered for a future contract. Thanks for taking the time to read this. I look forward to hearing from you more as the contract progresses. Thank you." (A LPHA team member new to the MCH Services contract)
- "I received an email regarding the proposed use of funds for FFY 2023 and wanted to submit feedback after reviewing the proposal. While several critical areas have been identified for improvement in maternal child care, unfortunately and understandably not all can be addressed in one year. Nonetheless, there are definitely some focal points that could be targeted. The following items I felt personally have demonstrated a desperate need for additional resources for both inpatients and outpatients. Pregnancy and Infant loss is a very significant and problematic issue in our communities. There is a strong need for both clinician and patient education, more fluent documentation for historical recordkeeping/ statistical reporting, and support groups or services for patients and families that have experienced pregnancy or infant loss. Breastfeeding support in the immediate postpartum period and throughout infancy for parents. Initial support is such a critical point of success for families that more support is imperative. Early informative education for patients is crucial to

prevent any intrapartum and postpartum educational barriers that can arise, when teaching is not initiated until after delivery. The significance of breastfeeding-informed education in addition to formula shortage, combined with the cost of breastfeeding supplies and access to breastfeeding difficulties, can all lead to breastfeeding frustration and failure regardless of determination for success. Thank you for the opportunity to submit my recommendations to the proposed funding and look forward to seeing future improvements with maternal child patients.” (Clinical Director of hospital-based women and neonatal services)

- “Will this be something rural health clinics can apply for?” (Rural Health Clinic Administrator)
- “I would like more information on funding opportunities for my community based organization. We are aimed at giving mothers the necessary in-home services and community resources to attack postpartum depression.” (Community Program Director)
- “I was hoping you could point me in the right direction regarding how to apply for funding from Missouri’s MCH funding.” (Non-profit Director)

Responses were sent by the MCH Director to each person/organization who provided comment on the PUF. All input will be taken into consideration in ongoing Title V MHC Program discussion and planning.

Engagement/Input for Ongoing Title V MCH Block Grant Implementation

Ongoing opportunities for input regarding the Title V MCH Block Grant are also available throughout the year. Virtual and in-person Public Health System meetings involve DHSS senior management and LPHA administrators and include discussions focused on a variety of public health topics including MCH issues. There have been ongoing discussions regarding the FFY 2021-2025 Title V MCH Block Grant State Action Plan and the COVID-19 pandemic. Multiple local public health administrators and MCH coordinators have expressed gratefulness for the allowance to use Title V MCH contract funding to cover expenses related to: COVID-19 outbreak investigations; providing education about COVID-19 to mothers, pregnant woman, children, adolescents, and CYSHCN and their families; working with emergency preparedness staff to assure the needs of the MCH population are addressed; mobilizing public health nurses to support a call center, conduct case investigation and/or monitoring, and deliver health services to the MCH population; partnering with parent networks, health care providers, schools, child care providers, and other state agencies to provide accurate and reliable information and promote vaccinations to families; and eengaging community leaders, including faith-based leaders, to educate community members about strategies for preventing illness.

The Title V MCH core team developed a stakeholder survey to solicit further individual and organizational stakeholder input on the State Action Plan, challenges to improving MCH outcomes, emerging MCH issues and needs, and program performance metrics. The survey, disseminated electronically, was completed by nearly 170 individuals, representing LPHAs, state agencies, community and faith-based organizations, health care professionals, parents/caregivers of infants, children, adolescents, and/or children and youth with special health care needs (CYSHCN), and adolescents and adolescent/youth leaders. The impact of the COVID-19 pandemic on the ability to effectively deliver services due to either staff turnover or redirection of staff priorities to COVID-19 duties emerged as a major theme from the preliminary analysis. Recommendations to meet the objectives of the state action plan included extension of Medicaid during the postpartum period to improve maternal mental health and preventive care education through schools, healthcare providers, social media, and public service announcements to increase awareness of preventive practices as well as programs and services available at the local and/or state level. Emerging MCH priority needs identified were increases in Sexually Transmitted Infections (STIs) and lack of access to family planning and sexual education. The survey was organized around the domains and priorities in the FFY 2021-2025 MCH State Action Plan. More in-depth analysis of survey responses will be completed, and findings will be used to strengthen and develop strategies and activities to address the priority needs identified as part of the state action plan and develop plans to address the emerging needs of the MCH population.

Examples of other meetings in which the DHSS seeks input from those considered “MCH Stakeholders” are the Maternal-Child Learning Action Network, MO HealthNet Maternal Health Coordination, ParentLink Advisory Board, Genetics Advisory Committee, Council for Adolescent and School Health (CASH), Missouri Injury and Violence Prevention Advisory Committee (MIVPAC), Pregnancy Associated Mortality Review (PAMR) board, Women’s Health Council, Early Childhood Comprehensive System Steering Committee, Parent Advisory Council, Safe Sleep Coalition, Missouri Brain Injury Advisory Council, Community Health Worker Advisory Committee, Kansas City Perinatal Recovery Collaborative, Missouri Bootheel Regional Consortium, Bootheel Babies and Families, Nurture KC, Missouri Child Psychiatry Access Project Steering Committee, and Missouri Association for Infant and Early Childhood Mental Health, to name a few. In addition, collaborative calls with Healthy Start grantees allow an opportunity to share resources and discuss program updates and opportunities for collaboration.

In summary, the DHSS recognizes the critical role of Title V MCH funds in addressing the ongoing needs of Missouri’s MCH population. Input from the MCH stakeholders and public served an important role in the development of this application and, most importantly, in the ongoing development and implementation of the State Action Plan. The DHSS collaborates with partners and stakeholders and continually seeks opportunities to obtain input from other sources, and stakeholder engagement is an ongoing priority. Responses received in response to the PUF provide the opportunity to engage with new stakeholders and inform the public of the Title V MCH Services Block Grant history, purpose, goals, funding methodology, and performance measurement and the Missouri MCH State Action Plan.

The DHSS Maternal Child Health Block Grant (MCHBG) [webpage](#) lists Missouri’s National and State Priority Areas, provides links to key Title V MCH resources, and has a direct link to email any questions and/or comments regarding the MCHBG. The FFY 2023 Application and FFY 2021 Annual Report will be added to this webpage once the final document is available and will remain available throughout the duration of the grant. A link is also currently on the webpage to direct the reader to the Title V Information System (TVIS) website.

III.G. Technical Assistance

As the Missouri Title V MCH Program continues to implement the FY 2021-2025 State Action Plan, areas of needed technical assistance are identified. Several current and ongoing topics for possible technical assistance have been discussed among the Title V MCH Core Team. Should the team decide to pursue technical assistance on one or more of the following topic areas, a Technical Assistance Request Form will be completed.

- Building program and policy evaluation capacity.
- Expanded statewide implementation of the medical home model for children with and without special health care needs.
- Strengthening state-level capacity to actively engage youth leaders and improve the health of adolescents.
- Applying Return on Investment (RoI) and Economic Impact (EI) analyses to programs and initiatives receiving Title V MCH Block Grant funding to evaluate value and impact of current Title V funding allocations.
- Development of a toolkit, compiled from annual state reports, to share successes and best practice approaches successfully implemented by LPHAs and community partners and/or to promote use of the AMCHP MCH Innovations Database (both submission and review) among MCH stakeholders/partners.
- Meaningful integration of the principles of justice, equity, diversity and inclusion and evidence-based continuous quality improvement.

IV. Title V-Medicaid IAA/MOU

The Title V-Medicaid IAA/MOU is uploaded as a PDF file to this section - [DHSS MOUs with DSS-DESE-DMH.pdf](#)

V. Supporting Documents

The following supporting documents have been provided to supplement the narrative discussion.

Supporting Document #01 - [References-Resources-Data Sources.pdf](#)

Supporting Document #02 - [DHSS Strategic Placemat-Overview_Jan 2022.pdf](#)

Supporting Document #03 - [DHSS Title V MCHBG Contract_DESE Office of Childhood_Final Draft_11-9-2021.pdf](#)

Supporting Document #04 - [FFY2022 MCH Services Contract SoW.pdf](#)

Supporting Document #05 - [DHSS-related Acronyms.pdf](#)

VI. Organizational Chart

The Organizational Chart is uploaded as a PDF file to this section - [DCPH-DSDS-OoC Org Charts.pdf](#)

VII. Appendix

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Form 2
MCH Budget/Expenditure Details

State: Missouri

	FY 23 Application Budgeted	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 13,064,561	
A. Preventive and Primary Care for Children	\$ 4,060,522	(31%)
B. Children with Special Health Care Needs	\$ 3,984,604	(30.4%)
C. Title V Administrative Costs	\$ 1,067,496	(8.2%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 9,112,622	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 9,987,230	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 9,987,230	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 9,987,230		
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 23,051,791	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.		
10. OTHER FEDERAL FUNDS(Subtotal of all funds under item 9)	\$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 23,051,791	

OTHER FEDERAL FUNDS	FY 23 Application Budgeted
No Other Federal Programs were provided by the State on Form 2 Line 9.	

	FY 21 Annual Report Budgeted		FY 21 Annual Report Expended	
1. FEDERAL ALLOCATION (Referenced items on the Application Face Sheet [SF-424] apply only to the Application Year)	\$ 12,971,226 (FY 21 Federal Award: \$ 12,299,305)		\$ 12,299,305	
A. Preventive and Primary Care for Children	\$ 4,074,879	(31.4%)	\$ 3,738,989	(30.4%)
B. Children with Special Health Care Needs	\$ 3,896,133	(30%)	\$ 3,714,391	(30.2%)
C. Title V Administrative Costs	\$ 1,057,589	(8.2%)	\$ 941,011	(7.7%)
2. Subtotal of Lines 1A-C (This subtotal does not include Pregnant Women and All Others)	\$ 9,028,601		\$ 8,394,391	
3. STATE MCH FUNDS (Item 18c of SF-424)	\$ 9,987,230		\$ 9,987,230	
4. LOCAL MCH FUNDS (Item 18d of SF-424)	\$ 0		\$ 0	
5. OTHER FUNDS (Item 18e of SF-424)	\$ 0		\$ 0	
6. PROGRAM INCOME (Item 18f of SF-424)	\$ 0		\$ 0	
7. TOTAL STATE MATCH (Lines 3 through 6)	\$ 9,987,230		\$ 9,987,230	
A. Your State's FY 1989 Maintenance of Effort Amount \$ 9,987,230				
8. FEDERAL-STATE TITLE V BLOCK GRANT PARTNERSHIP SUBTOTAL (Total lines 1 and 7)	\$ 22,958,456		\$ 22,286,535	
9. OTHER FEDERAL FUNDS Please refer to the next page to view the list of Other Federal Programs provided by the State on Form 2.				
10. OTHER FEDERAL FUNDS (Subtotal of all funds under item 9)	\$ 0		\$ 0	
11. STATE MCH BUDGET/EXPENDITURE GRAND TOTAL (Partnership Subtotal + Other Federal MCH Funds Subtotal)	\$ 22,958,456		\$ 22,286,535	

OTHER FEDERAL FUNDS	FY 21 Annual Report Budgeted	FY 21 Annual Report Expended
No Other Federal Programs were provided by the State on Form 2 Line 9.		

Form Notes for Form 2:

None

Field Level Notes for Form 2:

1.	Field Name:	1. FEDERAL ALLOCATION
	Fiscal Year:	2023
	Column Name:	Application Budgeted
	Field Note: Missouri is applying for \$13,064,561, which is higher than what the state has historically received in previous years. This amount reflects the total funds it will take to implement the planned strategies and initiatives and meet the needs of the Maternal and Child populations as illustrated in the program narratives.	
2.	Field Name:	1.FEDERAL ALLOCATION
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: As of 6/30/2022, \$10,318,649 of the total FY21 award amount (\$12,299,305) had been expended. Plans are in place to ensure the remaining FY21 funds (\$1,980,656) will be expended by the end of the two-year grant cycle ending September 30, 2022. The FFR will include final expenditure data and the total amount expended at grant closeout.	
3.	Field Name:	Federal Allocation, A. Preventive and Primary Care for Children:
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Preventive and Primary Care for Children based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022. As of June 30, 2022, actual expenditures totaled \$3,275,034. Of the remaining FY21 funds to be expended, at least \$414,758 of additional funding will be expended for Preventive and Primary Care for Children to meet the minimum of 30% (\$3,689,792) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.	
4.	Field Name:	Federal Allocation, B. Children with Special Health Care Needs:
	Fiscal Year:	2021
	Column Name:	Annual Report Expended

Field Note:

This is an estimated total expenditure amount for Children with Special Health Care Needs based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022. As of June 30, 2022, actual expenditures totaled \$2,930,084. Of the remaining FY21 funds to be expended, at least \$759,708 of additional funding will be expended for Children with Special Health Care Needs to meet the minimum of 30% (\$3,689,792) of the Federal Allocation. The FFR will include final expenditure data and the total amount expended at grant closeout.

5.	Field Name:	Federal Allocation, C. Title V Administrative Costs:
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Fiscal Year:	2021
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Column Name:	Annual Report Expended
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Field Note:

This is an estimated total expenditure amount for Administrative Costs based on the expectation that all remaining FY21 funds will be expended by the end of the the two-year grant cycle ending September 30, 2022. Administrative costs are anticipated to fall under the allowable 10% maximum. The FFR will include final expenditure data and the total amount expended at grant closeout.

Data Alerts: None

Form 3a
Budget and Expenditure Details by Types of Individuals Served
State: Missouri

I. TYPES OF INDIVIDUALS SERVED

IA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	\$ 2,168,007	\$ 1,901,084
2. Infants < 1 year	\$ 1,780,048	\$ 1,999,433
3. Children 1 through 21 Years	\$ 4,060,522	\$ 3,738,989
4. CSHCN	\$ 3,984,604	\$ 3,714,391
5. All Others	\$ 3,884	\$ 4,397
Federal Total of Individuals Served	\$ 11,997,065	\$ 11,358,294

IB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Pregnant Women	\$ 1,675,755	\$ 1,619,092
2. Infants < 1 year	\$ 922,802	\$ 793,513
3. Children 1 through 21 Years	\$ 461,952	\$ 1,042,078
4. CSHCN	\$ 6,420,061	\$ 6,025,887
5. All Others	\$ 506,660	\$ 506,660
Non-Federal Total of Individuals Served	\$ 9,987,230	\$ 9,987,230
Federal State MCH Block Grant Partnership Total	\$ 21,984,295	\$ 21,345,524

Form Notes for Form 3a:

None

Field Level Notes for Form 3a:

1.	Field Name:	IA. Federal MCH Block Grant, 1. Pregnant Women
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Pregnant Women based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	
2.	Field Name:	IA. Federal MCH Block Grant, 2. Infant < 1 Year
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Infants < 1 year based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	
3.	Field Name:	IA. Federal MCH Block Grant, 3. Children 1 through 21 years
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Children 1 through 21 years based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	
4.	Field Name:	IA. Federal MCH Block Grant, 4. CSHCN
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for CSHCN based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	

Data Alerts: None

Form 3b
Budget and Expenditure Details by Types of Services
State: Missouri

II. TYPES OF SERVICES

IIA. Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	\$ 294,522	\$ 284,060
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 52,273	\$ 58,160
B. Preventive and Primary Care Services for Children	\$ 92,998	\$ 89,488
C. Services for CSHCN	\$ 149,251	\$ 136,412
2. Enabling Services	\$ 4,294,950	\$ 4,137,906
3. Public Health Services and Systems	\$ 8,475,089	\$ 7,877,339
4. Select the types of Federally-supported "Direct Services", as reported in II.A.1. Provide the total amount of Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 0
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 176,658
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
CSHCN Direct Care Payments		\$ 107,402
Direct Services Line 4 Expended Total		\$ 284,060
Federal Total	\$ 13,064,561	\$ 12,299,305

IIB. Non-Federal MCH Block Grant	FY 23 Application Budgeted	FY 21 Annual Report Expended
1. Direct Services	\$ 2,228,378	\$ 4,320,030
A. Preventive and Primary Care Services for all Pregnant Women, Mothers, and Infants up to Age One	\$ 1,640,092	\$ 3,731,744
B. Preventive and Primary Care Services for Children	\$ 0	\$ 0
C. Services for CSHCN	\$ 588,286	\$ 588,286
2. Enabling Services	\$ 434,684	\$ 349,712
3. Public Health Services and Systems	\$ 7,324,168	\$ 5,317,488
4. Select the types of Non-Federally-supported "Direct Services", as reported in II.B.1. Provide the total amount of Non-Federal MCH Block Grant funds expended for each type of reported service		
Pharmacy		\$ 0
Physician/Office Services		\$ 3,713,374
Hospital Charges (Includes Inpatient and Outpatient Services)		\$ 0
Dental Care (Does Not Include Orthodontic Services)		\$ 0
Durable Medical Equipment and Supplies		\$ 0
Laboratory Services		\$ 0
Other		
CSHCN Direct Care Payments		\$ 588,286
SUIDS Payments		\$ 18,370
Direct Services Line 4 Expended Total		\$ 4,320,030
Non-Federal Total	\$ 9,987,230	\$ 9,987,230

Form Notes for Form 3b:

None

Field Level Notes for Form 3b:

1.	Field Name:	IIA. Federal MCH Block Grant, 1. Direct Services
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Direct Services based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	
2.	Field Name:	IIA. Federal MCH Block Grant, 2. Enabling Services
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Enabling Services based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	
3.	Field Name:	IIA. Federal MCH Block Grant, 3. Public Health Services and Systems
	Fiscal Year:	2021
	Column Name:	Annual Report Expended
	Field Note: This is an estimated total expenditure amount for Public Health Services and Systems based on the expectation that all remaining FY21 funds will be expended by the end of the two-year grant cycle ending September 30, 2022.	

Form 4
Number and Percentage of Newborns and Others Screened Cases Confirmed and Treated
State: Missouri

Total Births by Occurrence: 70,183

Data Source Year: 2021

1. Core RUSP Conditions

Program Name	(A) Aggregate Total Number Receiving at Least One Valid Screen	(B) Aggregate Total Number of Out-of-Range Results	(C) Aggregate Total Number Confirmed Cases	(D) Aggregate Total Number Referred for Treatment
Core RUSP Conditions	68,824 (98.1%)	3,352	255	255 (100.0%)

Program Name(s)				
3-Hydroxy-3-Methylglutaric Aciduria	3-Methylcrotonyl-Coa Carboxylase Deficiency	Argininosuccinic Aciduria	Biotinidase Deficiency	Carnitine Uptake Defect/Carnitine Transport Defect
Citrullinemia, Type I	Classic Galactosemia	Classic Phenylketonuria	Congenital Adrenal Hyperplasia	Critical Congenital Heart Disease
Cystic Fibrosis	Glutaric Acidemia Type I	Glycogen Storage Disease Type II (Pompe)	Hearing Loss	Holocarboxylase Synthase Deficiency
Homocystinuria	Isovaleric Acidemia	Long-Chain L-3 Hydroxyacyl-CoA Dehydrogenase Deficiency	Maple Syrup Urine Disease	Medium-Chain Acyl-CoA Dehydrogenase Deficiency
Methylmalonic Acidemia (Cobalamin Disorders)	Methylmalonic Acidemia (Methylmalonyl-CoA Mutase)	Mucopolysaccharidosis Type 1	Primary Congenital Hypothyroidism	Propionic Acidemia
S, β -Thalassemia	S,C Disease	S,S Disease (Sickle Cell Anemia)	Severe Combined Immunodeficiencies	Spinal Muscular Atrophy Due To Homozygous Deletion Of Exon 7 In SMN1
β -Ketothiolase Deficiency	Trifunctional Protein Deficiency	Tyrosinemia, Type I	Very Long-Chain Acyl-CoA Dehydrogenase Deficiency	X-Linked Adrenoleukodystrophy

2. Other Newborn Screening Tests

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Krabbe disease	68,824 (98.1%)	11	2	2 (100.0%)
Fabry disease	68,824 (98.1%)	56	25	25 (100.0%)
Gaucher disease	68,824 (98.1%)	4	2	2 (100.0%)
Hunter disease	68,824 (98.1%)	5	3	3 (100.0%)
Arginemia	68,824 (98.1%)	0	0	0 (0%)
Citrullinemia type II	68,824 (98.1%)	0	0	0 (0%)
Critical congenital heart disease	68,824 (98.1%)	104	0	0 (0%)
Defects of biotin cofactor biosynthesis	68,824 (98.1%)	5	0	0 (0%)
Defects of biotin cofactor regeneration	68,824 (98.1%)	5	0	0 (0%)
Hyperphenylalaninemia	68,824 (98.1%)	5	0	0 (0%)
Hypermethioninemia	68,824 (98.1%)	0	0	0 (0%)
Tyrosinemia type II	68,824 (98.1%)	4	0	0 (0%)
Tyrosinemia type III	68,824 (98.1%)	4	0	0 (0%)
Carnitine acylcarnitine translocase deficiency	68,824 (98.1%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency I	68,824 (98.1%)	0	0	0 (0%)
Carnitine palmitoyl transferase deficiency II	68,824 (98.1%)	0	0	0 (0%)

Program Name	(A) Total Number Receiving at Least One Screen	(B) Total Number Presumptive Positive Screens	(C) Total Number Confirmed Cases	(D) Total Number Referred for Treatment
Dienoyl-CoA reductase deficiency	68,824 (98.1%)	0	0	0 (0%)
Glutaric acidemia type II	68,824 (98.1%)	0	0	0 (0%)
Medium-chain ketoacyl-CoA thiolase deficiency	68,824 (98.1%)	0	0	0 (0%)
Medium/Short chain L-3-hydroxy axyl-CoA dehydrogenase deficiency	68,824 (98.1%)	0	0	0 (0%)
Short-chain acyl-CoA dehydrogenase deficiency	68,824 (98.1%)	7	7	7 (100.0%)
2-Methyl-3-hydroxybutyric aciduria	68,824 (98.1%)	0	0	0 (0%)
2-Methylbutyryl-CoA dehydrogenase deficiency	68,824 (98.1%)	1	1	1 (100.0%)
2-Methylbutyrylglycinuria	68,824 (98.1%)	2	2	2 (100.0%)
3-Methylglutaconic aciduria	68,824 (98.1%)	0	0	0 (0%)
Isobutyryl-CoA dehydrogenase deficiency	68,824 (98.1%)	0	0	0 (0%)
Malonic acidemia	68,824 (98.1%)	0	0	0 (0%)
Various other hemoglobinopathies	68,824 (98.1%)	4	4	4 (100.0%)
CFTR-Related Metabolic Syndrome	68,824 (98.1%)	141	2	2 (100.0%)
T-cell related lymphocyte deficiencies	68,824 (98.1%)	2	1	1 (100.0%)
Maternal 3-MCC	68,824 (98.1%)	0	0	0 (0%)

3. Screening Programs for Older Children & Women

None

4. Long-Term Follow-Up

Once the infant is confirmed and put on treatment the case is closed. Currently we are doing some long term follow-up on LSD cases as we remain in contact with these families. We are exploring long-term follow-up possibilities.

Form Notes for Form 4:

None

Field Level Notes for Form 4:

1.	Field Name:	Critical congenital heart disease - Total Number Confirmed Cases
	Fiscal Year:	2021
	Column Name:	Other Newborn
	Field Note:	Missouri conducts passive surveillance for CCHD screening.
2.	Field Name:	Critical congenital heart disease - Total Number Referred For Treatment
	Fiscal Year:	2021
	Column Name:	Other Newborn
	Field Note:	Missouri conducts passive surveillance for CCHD screening.
3.	Field Name:	Defects of bipterin cofactor biosynthesis - Total Number Presumptive Positive Screens
	Fiscal Year:	2021
	Column Name:	Other Newborn
	Field Note:	This disorder has the same screening markers and is referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.
4.	Field Name:	Defects of bipterin cofactor regeneration - Total Number Presumptive Positive Screens
	Fiscal Year:	2021
	Column Name:	Other Newborn
	Field Note:	This disorder has the same screening markers and is referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.
5.	Field Name:	Hyperphenylalaninemia - Total Number Presumptive Positive Screens
	Fiscal Year:	2021
	Column Name:	Other Newborn
	Field Note:	This disorder has the same screening markers and is referred as a presumptive positive for one of several possible disorders. It is only through further testing by the referral center that the disorder is confirmed as one of the specific disorders.

Data Alerts: None

Form 5
Count of Individuals Served by Title V & Total Percentage of Populations Served by Title V

State: Missouri

Annual Report Year 2021

Form 5a – Count of Individuals Served by Title V
(Direct & Enabling Services Only)

		Primary Source of Coverage				
Types Of Individuals Served	(A) Title V Total Served	(B) Title XIX %	(C) Title XXI %	(D) Private / Other %	(E) None %	(F) Unknown %
1. Pregnant Women	2,892	38.4	0.0	59.2	0.0	2.4
2. Infants < 1 Year of Age	15,636	38.4	0.0	59.2	0.0	2.4
3. Children 1 through 21 Years of Age	46,507	28.0	0.0	63.0	0.0	9.0
3a. Children with Special Health Care Needs 0 through 21 years of age^	1,929	40.0	0.0	57.0	0.0	3.0
4. Others	4,795	10.0	0.0	79.0	0.0	11.0
Total	69,830					

Form 5b – Total Percentage of Populations Served by Title V
(Direct, Enabling, and Public Health Services and Systems)

Populations Served by Title V	Reference Data	Used Reference Data?	Denominator	Total % Served	Form 5b Count (Calculated)	Form 5a Count
1. Pregnant Women	69,285	No	69,242	52.6	36,421	2,892
2. Infants < 1 Year of Age	69,960	Yes	69,960	99.6	69,680	15,636
3. Children 1 through 21 Years of Age	1,615,897	Yes	1,615,897	10.3	166,437	46,507
3a. Children with Special Health Care Needs 0 through 21 years of age^	356,072	Yes	356,072	16.2	57,684	1,929
4. Others	4,464,002	Yes	4,464,002	1.3	58,032	4,795

^Represents a subset of all infants and children.

Form Notes for Form 5:

None

Field Level Notes for Form 5a:

1.	Field Name:	Pregnant Women Total Served
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Expectant moms downloading the Count the Kicks App, FFY 2021: 715 Mothers receiving home visiting services through Building Blocks, FFY 2021: 254 Mothers served by Healthy Families Missouri Home Visiting Program, FFY 2021: 17 Prenatal care services through Local Public Health Agencies, FFY 2021: 1906 Total: 2892		
2.	Field Name:	Infants Less Than One YearTotal Served
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Infants receiving home visiting services through Building Blocks FFY 2021: 107 Infants served by Healthy Families Missouri Home Visiting Program FFY 2021: 27 Portable cribs and Safe Sleep education delivered through Local Public Health Agencies (LPHAs) to low income families FFY 2021: 83 Infants receiving services through Local Public Health Agencies, FFY 2021: 15,419 Total FFY 2021: 15,636		
3.	Field Name:	Children 1 through 21 Years of Age
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Child Regulation (Child Care Services) FFY 2021: 151 Teen Outreach Program, FFY 2021: 45 EAP, FFY 2021: 1,926 AAP: FFY 2021: 1,372 SAFE-Exams, FFY 2021: 2,961 CARE (Physical Abuse) Exams, FFY 2021: 1,386 Oral Health (PSP): FFY 2021: 35,873* Children with Special Health Care Needs, FFY 2021: 1,929 Students w SHCN under SHS Contracts FFY 2021: 2,422 Adolescent Health/Abstinence (AEGP), FFY 2021: 269 Other Teen Pregnancy Prevention Education (through PREP), FFY 2021: 102 Total FFY 2021: 48,436 *Oral Health Preventative Service Program saw a significant decrease in children aged 1-21 served due to the difficulty of getting into schools to serve children. Many schools were not open to visitors even for oral care/screenings because of COVID.		

4.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Children and Youth with Special Health Care Needs Program SFY 2021: 621 Healthy Children and Youth Program SFY 2021: 1,308 Total SFY 2021: 1,929		
5.	Field Name:	Others
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Nurse training program participants FFY 2021: 522 Child Care Referrals for families of CYSHCN FFY 2021: 172 Teachers trained on inclusion services FFY 2021: 2,613 Number of Child Passenger Safety (CPS) technicians trained through CPS training FFY 2021: 234 Trained in Home Visiting programs FFY 2021: 308 Health Care Providers, foster parents training on Current Adolescent Health Issues FFY 2021: 120 Lead Nurse Learning Community FFY 2021: 826 Total SFY 2021: 4,795		
6.	Field Name:	Total_TotalServed
	Fiscal Year:	2021
Field Note: Fiscal Year: 2021 Pregnant Women FFY 2021: 2,892 Infants < 1 Year Age FFY 2021: 15,636 Children 01 through 21 Years of Age FFY 2021: 46,507 Children with Special Health Care Needs (Subtotal Children of 0-21 Years of Age) FFY 2021: 1,929 Others FFY 2021: 4,795 Total FFY 2021: 71,759		

Field Level Notes for Form 5b:

1.	Field Name:	Pregnant Women Total % Served
	Fiscal Year:	2021
Field Note: Pregnancy and Beyond Books distributed FFY 2021: 23,987 MIECHV Home Visiting Program FFY 2021: 186 Prenatal care services through LPHAS FFY 2021: 1,906 Oral Health FFY 2021: 10,366 Numerator: Total FFY 2021: 36,445 Denominator: MODHSS Vital Statics File - Provisional Live Births, 2021: 69,242		
2.	Field Name:	Pregnant Women Denominator

	Fiscal Year:	2021
	Field Note:	MODHSS Vital Statics File - Provisional Live Births for 2021
3.	Field Name:	Infants Less Than One Year Total % Served
	Fiscal Year:	2021
	Field Note:	Numerator: Newborn Hearing Screenings FFY 2021: 69,692 Denominator: Data Source: National Vital Statistics System – MO Occurrent Live Births, 2020: 69,960
4.	Field Name:	Children 1 through 21 Years of Age Total % Served
	Fiscal Year:	2021
	Field Note:	<p>Children obesity prevention program FFY 2021: 181 Safe Kids FFY 2021: 31,016* Safe Ride Cards Distribution FFY 2021: 7,711 Referrals triage & reviewed (Child under 4 yrs) FFY 2021: 4,736 Child Regulation (Child Care Services) FFY 2021: 151 TEAMS School Districts FFY 2021: 10,938* School Health Participants FFY 2021: 16,569 Oral Health (PSP) FFY 2021: 35,873** CSHCN Served FFY 2021: 58,825 Numerator: Total FFY 2021: 166,000 Denominator: US Census Bureau Population Estimates, 2020: 1,615,897</p> <p>*The Bureau of Community Health & Wellness had difficulty working with as many districts during the reporting year than previous years. Additionally, the school districts vary greatly in enrollment and there were fewer districts with fewer students which caused the decrease in reach. **Oral Health Preventative Service Program saw a significant decrease in children aged 1-21 served due to the difficulty of getting into schools to serve children. Many schools were not open to visitors even for oral care/screenings because of COVID.</p>
5.	Field Name:	Children with Special Health Care Needs 0 through 21 Years of Age Total % Served
	Fiscal Year:	2021

Field Note:

Direct Services: (CYSHCN) Children & Youth with Special Health Care Needs Program FFY 2021: 1,929

Indirect Services: FFY 2021: 56,765

Brain Injury (Outreach with the Traumatic Brain Injury Grant) FFY 2021: 9,370*

Bureau of Special Health Care Needs (Community outreach, and printed materials) FFY 2021: 5,845*

(CYSHCN) (Community Outreach and printed materials) FFY 2021: 13,184

Healthy Children and Youth FFY 2021: 186

Special Health Services Web Inquiries FFY 2021: 28,180

Numerator: Total Services: SFY 2021: 58,825

Denominator: Data Source: National Survey of Children's Health CSHCN Prevalence Estimates 0-17 (2019-2020)
multiplied by US Census Bureau Population Estimates 0-21, 2020: 356,072

*The Bureau of Special Health Care Needs saw a significant decrease in those served from community outreach due to COVID inhibiting the ability conduct events/outreach comparable to previous years.

6.	Field Name:	Others Total % Served
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Fiscal Year:	2021
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Field Note:

Distribution of 10 Ways to Be a Better Dad FFY 2021: 10,141

Number of on Site Technical Assistance Visits FFY 2021: 138

Community Outreach Contacts FFY 2021: 46,799

Obesity Prevention Program FFY 2021: 43

MIECHV Trained in Home Visiting Programs FFY 2021: 401

Total FFY 2021: 57,522

Denominator: Data Source: US Census Bureau Population Estimates, 2020

Data Alerts: None

Form 6
Deliveries and Infants Served by Title V and Entitled to Benefits Under Title XIX

State: Missouri

Annual Report Year 2021

I. Unduplicated Count by Race/Ethnicity

	(A) Total	(B) Non- Hispanic White	(C) Non- Hispanic Black or African American	(D) Hispanic	(E) Non- Hispanic American Indian or Native Alaskan	(F) Non- Hispanic Asian	(G) Non- Hispanic Native Hawaiian or Other Pacific Islander	(H) Non- Hispanic Multiple Race	(I) Other & Unknown
1. Total Deliveries in State	69,662	50,719	9,579	4,622	184	1,606	225	2,276	451
Title V Served	26,760	15,883	6,266	2,598	88	374	136	1,193	222
Eligible for Title XIX	69,662	50,719	9,579	4,622	184	1,606	225	2,276	451
2. Total Infants in State	69,269	50,468	9,494	4,593	184	1,602	220	2,264	444
Title V Served	26,584	15,786	6,219	2,579	88	373	134	1,187	218
Eligible for Title XIX	69,269	50,468	9,494	4,593	184	1,602	220	2,264	444

Form Notes for Form 6:

None

Field Level Notes for Form 6:

1.	Field Name:	1. Total Deliveries in State
	Fiscal Year:	2021
	Column Name:	Total
	Field Note: These data are provisional as the fetal death data are not yet final.	
2.	Field Name:	1. Title V Served
	Fiscal Year:	2021
	Column Name:	Total
	Field Note: These data are provisional as the fetal death data are not yet final.	
3.	Field Name:	1. Eligible for Title XIX
	Fiscal Year:	2021
	Column Name:	Total
	Field Note: These data are provisional as the fetal death data are not yet final.	

Form 7
State MCH Toll-Free Telephone Line and Other Appropriate Methods Data

State: Missouri

A. State MCH Toll-Free Telephone Lines	2023 Application Year	2021 Annual Report Year
1. State MCH Toll-Free "Hotline" Telephone Number	(800) 835-5465	(800) 835-5465
2. State MCH Toll-Free "Hotline" Name	TEL-LINK	TEL-LINK
3. Name of Contact Person for State MCH "Hotline"	Megan Hammann	Megan Hammann
4. Contact Person's Telephone Number	(573) 526-0213	(573) 526-0213
5. Number of Calls Received on the State MCH "Hotline"		2,789

B. Other Appropriate Methods	2023 Application Year	2021 Annual Report Year
1. Other Toll-Free "Hotline" Names	Oral Health Program Calls/Special Health Services/Vaccines for Children Program/Genetics and Healthy Childhood/ WIC and Nutrition Services	Oral Health Program Calls/Special Health Services/Vaccines for Children Program/Genetics and Healthy Childhood/ WIC and Nutrition Services
2. Number of Calls on Other Toll-Free "Hotlines"		26,650
3. State Title V Program Website Address	https://health.mo.gov/living/families/mch-block-grant/	https://health.mo.gov/living/families/mch-block-grant/
4. Number of Hits to the State Title V Program Website		1,639
5. State Title V Social Media Websites		
6. Number of Hits to the State Title V Program Social Media Websites		

Form Notes for Form 7:

None

Form 8
State MCH and CSHCN Directors Contact Information

State: Missouri

1. Title V Maternal and Child Health (MCH) Director

Name	Martha J. Smith, MSN, RN
Title	MCH/Title V Director
Address 1	P.O. Box 570
Address 2	920 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(573) 751-6435
Extension	
Email	Martha.Smith@health.mo.gov

2. Title V Children with Special Health Care Needs (CSHCN) Director

Name	Lisa Crandall
Title	Bureau Chief, Bureau of Special Health Care Needs
Address 1	P.O. Box 570
Address 2	912 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(573) 751-6246
Extension	
Email	Lisa.Crandall@health.mo.gov

3. State Family or Youth Leader (Optional)

Name	Sheree Pursley
Title	Family Partner
Address 1	P.O. Box 570
Address 2	912 Wildwood Drive
City/State/Zip	Jefferson City / MO / 65102
Telephone	(800) 451-0669
Extension	
Email	Sheree.Pursley@health.mo.gov

Form Notes for Form 8:

None

Form 9
List of MCH Priority Needs

State: Missouri

Application Year 2023

No.	Priority Need
1.	Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.
2.	Promote safe sleep practices among newborns to reduce sleep-related infant deaths.
3.	Reduce obesity among children and adolescents.
4.	Reduce intentional and unintentional injuries among children and adolescents.
5.	Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.
6.	Enhance access to oral health care services for children.
7.	Promote Protective Factors for Youth and Families.
8.	Address Social Determinants of Health Inequities.

Form Notes for Form 9:

None

Field Level Notes for Form 9:

None

Form 9 State Priorities – Needs Assessment Year – Application Year 2021

No.	Priority Need	Priority Need Type (New, Revised or Continued Priority Need for this five-year reporting period)
1.	Improve pre-conception, prenatal and postpartum health care services for women of childbearing age.	Continued
2.	Promote safe sleep practices among newborns to reduce sleep-related infant deaths.	New
3.	Reduce obesity among children and adolescents.	New
4.	Reduce intentional and unintentional injuries among children and adolescents.	Continued
5.	Ensure coordinated, comprehensive and ongoing health care services for children with and without special health care needs.	Continued
6.	Enhance access to oral health care services for children.	New
7.	Promote Protective Factors for Youth and Families.	New
8.	Address Social Determinants of Health Inequities.	New

Form 10
National Outcome Measures (NOMs)

State: Missouri

Form Notes for Form 10 NPMs, NOMs, SPMs, SOMs, and ESMs.

None

NOM 1 - Percent of pregnant women who receive prenatal care beginning in the first trimester


Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	75.7 %	0.2 %	50,668	66,941
2019	75.6 %	0.2 %	52,721	69,768
2018	75.4 %	0.2 %	52,361	69,446
2017	76.6 %	0.2 %	52,597	68,679
2016	77.6 %	0.2 %	54,806	70,617
2015	77.2 %	0.2 %	55,511	71,931
2014	76.7 %	0.2 %	55,543	72,390
2013	75.3 %	0.2 %	54,031	71,734
2012	76.0 %	0.2 %	54,074	71,154
2011	76.5 %	0.2 %	55,134	72,054
2010	77.2 %	0.2 %	56,322	72,988

Legends:

 Indicator has a numerator <10 and is not reportable

 Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data	
	2021
Annual Indicator	73.1
Numerator	48,915
Denominator	66,947
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 1 - Notes:

None

Data Alerts: None

NOM 2 - Rate of severe maternal morbidity per 10,000 delivery hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	83.2	3.5	574	68,989
2018	80.1	3.4	560	69,920
2017	75.4	3.3	527	69,896
2016	70.2	3.1	502	71,513
2015	61.2	3.4	329	53,734
2014	65.9	3.0	473	71,741
2013	67.6	3.1	485	71,716
2012	74.5	3.2	537	72,112
2011	66.8	3.0	487	72,950
2010	73.1	3.2	538	73,592
2009	71.1	3.1	540	75,937
2008	59.2	2.8	461	77,822

Legends:

🚩 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	112.8
Numerator	759
Denominator	67,268
Data Source	Missouri Patient Abstract System
Data Source Year	2020

NOM 2 - Notes:

None

Data Alerts: None

NOM 3 - Maternal mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2016_2020	23.5	2.5	85	362,420
2015_2019	19.8	2.3	73	368,196
2014_2018	21.3	2.4	79	371,429

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	41.9
Numerator	29
Denominator	69,245
Data Source	Missouri Vital Statistics Death File
Data Source Year	2021

NOM 3 - Notes:

For 2021 provisional data, the 2020 denominator data was used because the exact total for 2021 is not yet available.

We have final data for 2020 as follows: Annual Indicator - 54.9; Numerator - 38; Denominator - 69,277.

Missouri Vital Statistics Death File was used as data source.

Data Alerts: None

NOM 4 - Percent of low birth weight deliveries (<2,500 grams)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	8.7 %	0.1 %	6,020	69,236
2019	8.8 %	0.1 %	6,356	72,072
2018	8.7 %	0.1 %	6,389	73,211
2017	8.7 %	0.1 %	6,336	72,968
2016	8.7 %	0.1 %	6,473	74,622
2015	8.3 %	0.1 %	6,248	74,992
2014	8.2 %	0.1 %	6,163	75,282
2013	8.0 %	0.1 %	6,033	75,182
2012	7.7 %	0.1 %	5,809	75,142
2011	7.9 %	0.1 %	5,995	75,814
2010	8.2 %	0.1 %	6,286	76,459
2009	8.1 %	0.1 %	6,393	78,865

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	8.9
Numerator	6,160
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 4 - Notes:

None

Data Alerts: None

NOM 5 - Percent of preterm births (<37 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	11.0 %	0.1 %	7,599	69,207
2019	10.9 %	0.1 %	7,832	72,032
2018	10.7 %	0.1 %	7,849	73,198
2017	10.6 %	0.1 %	7,702	72,948
2016	10.2 %	0.1 %	7,584	74,586
2015	10.0 %	0.1 %	7,504	74,962
2014	9.8 %	0.1 %	7,346	75,269
2013	9.6 %	0.1 %	7,195	74,902
2012	9.9 %	0.1 %	7,423	75,073
2011	9.6 %	0.1 %	7,269	75,588
2010	10.0 %	0.1 %	7,655	76,402
2009	9.9 %	0.1 %	7,803	78,681

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	11.3
Numerator	7,797
Denominator	69,158
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 5 - Notes:

None

Data Alerts: None

NOM 6 - Percent of early term births (37, 38 weeks)

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	28.3 %	0.2 %	19,595	69,207
2019	27.3 %	0.2 %	19,690	72,032
2018	26.4 %	0.2 %	19,325	73,198
2017	26.0 %	0.2 %	18,986	72,948
2016	25.1 %	0.2 %	18,713	74,586
2015	24.2 %	0.2 %	18,163	74,962
2014	24.4 %	0.2 %	18,340	75,269
2013	24.2 %	0.2 %	18,129	74,902
2012	25.3 %	0.2 %	19,020	75,073
2011	25.9 %	0.2 %	19,550	75,588
2010	27.2 %	0.2 %	20,759	76,402
2009	26.6 %	0.2 %	20,938	78,681

Legends:

🚩 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20, a confidence interval width >20% points or >1.2 times the estimate, or >10% missing data and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	29.1
Numerator	20,129
Denominator	69,158
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 6 - Notes:

None

Data Alerts: None

NOM 7 - Percent of non-medically indicated early elective deliveries

Data Source: CMS Hospital Compare

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020/Q3-2021/Q2	2.0 %			
2019/Q4-2020/Q3	2.0 %			
2019/Q1-2019/Q4	2.0 %			
2018/Q4-2019/Q3	2.0 %			
2018/Q3-2019/Q2	2.0 %			
2018/Q2-2019/Q1	2.0 %			
2018/Q1-2018/Q4	2.0 %			
2017/Q4-2018/Q3	2.0 %			
2017/Q3-2018/Q2	2.0 %			
2017/Q2-2018/Q1	2.0 %			
2017/Q1-2017/Q4	2.0 %			
2016/Q4-2017/Q3	2.0 %			
2016/Q3-2017/Q2	2.0 %			
2016/Q2-2017/Q1	2.0 %			
2016/Q1-2016/Q4	2.0 %			
2015/Q4-2016/Q3	2.0 %			
2015/Q3-2016/Q2	2.0 %			
2015/Q2-2016/Q1	1.0 %			
2015/Q1-2015/Q4	1.0 %			
2014/Q4-2015/Q3	2.0 %			
2014/Q3-2015/Q2	2.0 %			
2014/Q2-2015/Q1	2.0 %			
2014/Q1-2014/Q4	3.0 %			
2013/Q4-2014/Q3	3.0 %			
2013/Q3-2014/Q2	4.0 %			
2013/Q2-2014/Q1	5.0 %			

Legends:

NOM 7 - Notes:

None


Data Alerts: None

NOM 8 - Perinatal mortality rate per 1,000 live births plus fetal deaths

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.8	0.3	422	72,324
2018	5.9	0.3	430	73,467
2017	6.0	0.3	439	73,244
2016	6.6	0.3	495	74,934
2015	6.6	0.3	497	75,285
2014	5.6	0.3	422	75,558
2013	6.3	0.3	473	75,497
2012	6.4	0.3	483	75,659
2011	6.1	0.3	465	76,318
2010	6.1	0.3	470	76,978
2009	6.4	0.3	506	79,127

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	5.8
Numerator	401
Denominator	69,463
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 8 - Notes:

We have final data for 2020 as follows: Annual Indicator - 6.1; Numerator - 425; Denominator - 69,510.

The data source is Missouri Department of Health Vital Statistics files.

Data Alerts: None

NOM 9.1 - Infant mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.1	0.3	443	72,127
2018	6.3	0.3	465	73,269
2017	6.3	0.3	457	73,034
2016	6.6	0.3	492	74,705
2015	6.5	0.3	487	75,061
2014	6.1	0.3	461	75,360
2013	6.5	0.3	491	75,296
2012	6.6	0.3	498	75,446
2011	6.3	0.3	482	76,117
2010	6.6	0.3	505	76,759
2009	7.1	0.3	558	78,905

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	5.7
Numerator	392
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 9.1 - Notes:

We have final data for 2020 as follows: Annual Indicator - 5.7; Numerator - 392; Denominator - 69,277.

The data source is the Missouri Department of Health Vital Statistics files.

Data Alerts: None

NOM 9.2 - Neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	3.9	0.2	283	72,127
2018	3.8	0.2	279	73,269
2017	3.8	0.2	279	73,034
2016	4.2	0.2	317	74,705
2015	4.2	0.2	319	75,061
2014	3.8	0.2	283	75,360
2013	4.4	0.2	330	75,296
2012	4.2	0.2	319	75,446
2011	4.0	0.2	307	76,117
2010	4.1	0.2	316	76,759
2009	4.5	0.2	357	78,905

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	3.3
Numerator	230
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 9.2 - Notes:

We have final data for 2020 as follows: Annual Indicator - 3.6; Numerator - 246; Denominator - 69,277.

The data source is the Missouri DHSS Vital Statistics files.

Data Alerts: None

NOM 9.3 - Post neonatal mortality rate per 1,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	2.2	0.2	160	72,127
2018	2.5	0.2	186	73,269
2017	2.4	0.2	178	73,034
2016	2.3	0.2	175	74,705
2015	2.2	0.2	168	75,061
2014	2.4	0.2	178	75,360
2013	2.2	0.2	162	75,296
2012	2.4	0.2	180	75,446
2011	2.3	0.2	175	76,117
2010	2.5	0.2	189	76,759
2009	2.5	0.2	201	78,905

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	2.3
Numerator	162
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 9.3 - Notes:

We have final data for 2020 as follows: Annual Indicator - 2.1; Numerator - 146; Denominator - 69,277.

The data source is the Missouri DHSS Vital Statistics files.

Data Alerts: None

NOM 9.4 - Preterm-related mortality rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	177.5	15.7	128	72,127
2018	225.2	17.6	165	73,269
2017	179.4	15.7	131	73,034
2016	223.5	17.3	167	74,705
2015	206.5	16.6	155	75,061
2014	209.7	16.7	158	75,360
2013	248.4	18.2	187	75,296
2012	200.1	16.3	151	75,446
2011	202.3	16.3	154	76,117
2010	218.9	16.9	168	76,759
2009	223.1	16.8	176	78,905

Legends:

🚫 Indicator has a numerator <10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	150.2
Numerator	104
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 9.4 - Notes:

We have final data for 2020 as follows: Annual Indicator - 158.8; Numerator - 110; Denominator - 69,277.

The data source is the Missouri DHSS Vital Statistics files.

Data Alerts: None

NOM 9.5 - Sudden Unexpected Infant Death (SUID) rate per 100,000 live births

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	95.7	11.5	69	72,127
2018	94.2	11.3	69	73,269
2017	124.6	13.1	91	73,034
2016	105.7	11.9	79	74,705
2015	95.9	11.3	72	75,061
2014	112.8	12.2	85	75,360
2013	94.3	11.2	71	75,296
2012	110.0	12.1	83	75,446
2011	85.4	10.6	65	76,117
2010	96.4	11.2	74	76,759
2009	109.0	11.8	86	78,905

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	96.8
Numerator	67
Denominator	69,245
Data Source	Missouri DHSS Vital Statistics Files
Data Source Year	2021

NOM 9.5 - Notes:

We have final data for 2020 as follows: Annual Indicator - 105.4; Numerator - 73; Denominator - 69,277.

The data source is the Missouri DHSS Vital Statistics files.

Data Alerts: None

NOM 10 - Percent of women who drink alcohol in the last 3 months of pregnancy

Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	6.2 %	0.9 %	4,007	64,679
2019	5.8 %	0.7 %	3,837	66,556
2018	5.5 %	0.9 %	3,743	67,515
2017	5.8 %	0.8 %	3,938	67,929
2016	5.1 %	0.8 %	3,545	69,899
2015	6.5 %	0.8 %	4,528	69,911
2014	6.5 %	0.8 %	4,612	70,717
2013	8.4 %	0.9 %	5,958	70,904
2012	8.5 %	1.1 %	5,955	70,491
2011	5.4 %	0.7 %	3,883	71,474
2010	5.2 %	0.7 %	3,717	71,870
2009	4.8 %	0.7 %	3,573	74,298
2007	4.5 %	0.7 %	3,460	76,679

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has an unweighted denominator between 30 and 59 or confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

NOM 10 - Notes:

None

Data Alerts: None

NOM 11 - Rate of neonatal abstinence syndrome per 1,000 birth hospitalizations

Data Source: HCUP - State Inpatient Databases (SID)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	5.3	0.3	370	69,603
2018	5.3	0.3	376	70,534
2017	5.1	0.3	357	70,263
2016	5.9	0.3	422	71,724
2015	5.1	0.3	276	54,065
2014	4.4	0.3	318	72,540
2013	4.2	0.2	304	72,289
2012	3.5	0.2	251	72,668
2011	3.1	0.2	227	73,592
2010	2.8	0.2	212	74,422
2009	2.0	0.2	150	76,501
2008	1.7	0.2	131	78,195

Legends:

🚩 Indicator has a numerator ≤10 and is not reportable

⚡ Indicator has a numerator <20 and should be interpreted with caution

State Provided Data

	2021
Annual Indicator	10.4
Numerator	701
Denominator	67,268
Data Source	MO PAS and MO DHSS Vital Statistics
Data Source Year	2020

NOM 11 - Notes:

None

Data Alerts: None

NOM 12 - Percent of eligible newborns screened for heritable disorders with on time physician notification for out of range screens who are followed up in a timely manner. (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 12 - Notes:

None

Data Alerts: None

NOM 13 - Percent of children meeting the criteria developed for school readiness (DEVELOPMENTAL)

Federally available Data (FAD) for this measure is not available/reportable.

NOM 13 - Notes:

None

Data Alerts: None

NOM 14 - Percent of children, ages 1 through 17, who have decayed teeth or cavities in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	11.3 %	1.3 %	144,593	1,281,061
2018_2019	13.6 %	1.4 %	174,536	1,287,345
2017_2018	12.4 %	1.5 %	161,455	1,301,281
2016_2017	11.2 %	1.3 %	145,427	1,293,510
2016	11.7 %	1.4 %	151,883	1,296,123

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 14 - Notes:

None


Data Alerts: None

NOM 15 - Child Mortality rate, ages 1 through 9, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	20.4	1.7	138	675,065
2019	19.7	1.7	133	675,493
2018	20.2	1.7	137	678,402
2017	21.6	1.8	147	682,079
2016	21.2	1.8	145	684,438
2015	21.7	1.8	149	687,559
2014	19.6	1.7	135	689,889
2013	19.3	1.7	134	694,290
2012	22.0	1.8	153	696,365
2011	20.9	1.7	146	698,014
2010	17.7	1.6	125	704,581
2009	24.5	1.9	172	700,639

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	22.9
Numerator	155
Denominator	677,437
Data Source	Missouri Vital Statistics Death File
Data Source Year	2021

NOM 15 - Notes:

For 2021 provisional data, the 2020 denominator data was used because the exact total for 2021 is not yet available.

We have final data for 2020 as follows: Annual Indicator - 20.4; Numerator - 138; Denominator - 677,437.

Missouri Vital Statistics Death File was used as data source.

Data Alerts: None

NOM 16.1 - Adolescent mortality rate ages 10 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	47.4	2.5	369	778,428
2019	43.2	2.4	337	780,786
2018	45.2	2.4	354	783,327
2017	47.7	2.5	374	783,928
2016	41.7	2.3	327	785,023
2015	41.6	2.3	327	786,368
2014	35.4	2.1	279	787,156
2013	37.2	2.2	294	790,407
2012	39.0	2.2	311	798,190
2011	42.1	2.3	341	810,723
2010	42.5	2.3	349	820,711
2009	42.7	2.3	353	826,046

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	52.9
Numerator	412
Denominator	778,428
Data Source	Missouri Vital Statistics Death File
Data Source Year	2021

NOM 16.1 - Notes:

For 2021 provisional data, the 2020 denominator data was used because the exact total for 2021 is not yet available.

We have final data for 2020 as follows: Annual Indicator - 47.4; Numerator - 369; Denominator - 778,428.

Missouri Vital Statistics Death File was used as data source.

Data Alerts: None

NOM 16.2 - Adolescent motor vehicle mortality rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	16.7	1.2	195	1,169,485
2017_2019	18.5	1.3	217	1,174,314
2016_2018	19.2	1.3	227	1,180,579
2015_2017	19.6	1.3	232	1,186,213
2014_2016	17.8	1.2	211	1,188,480
2013_2015	17.6	1.2	210	1,190,800
2012_2014	17.4	1.2	208	1,197,220
2011_2013	19.8	1.3	241	1,215,589
2010_2012	20.5	1.3	254	1,241,119
2009_2011	21.4	1.3	271	1,266,664
2008_2010	22.7	1.3	291	1,284,102
2007_2009	26.6	1.4	343	1,290,664

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	19.3
Numerator	75
Denominator	388,427
Data Source	Missouri Vital Statistics Death File
Data Source Year	2021

NOM 16.2 - Notes:

For 2021 provisional data, the 2020 denominator data was used because the exact total for 2021 is not yet available.

We have final data for 2020 as follows: Annual Indicator - 17.8; Numerator - 69; Denominator - 388,427.

Missouri Vital Statistics Death File was used as data source.

Data Alerts: None

NOM 16.3 - Adolescent suicide rate, ages 15 through 19, per 100,000

Data Source: National Vital Statistics System (NVSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018_2020	14.5	1.1	169	1,169,485
2017_2019	16.3	1.2	192	1,174,314
2016_2018	17.2	1.2	203	1,180,579
2015_2017	14.9	1.1	177	1,186,213
2014_2016	12.8	1.0	152	1,188,480
2013_2015	10.7	1.0	127	1,190,800
2012_2014	9.7	0.9	116	1,197,220
2011_2013	9.5	0.9	115	1,215,589
2010_2012	9.2	0.9	114	1,241,119
2009_2011	8.3	0.8	105	1,266,664
2008_2010	9.1	0.8	117	1,284,102
2007_2009	9.1	0.8	117	1,290,664

Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**State Provided Data**

	2021
Annual Indicator	14.7
Numerator	57
Denominator	388,427
Data Source	Missouri Vital Statistics Death File
Data Source Year	2021

NOM 16.3 - Notes:

For 2021 provisional data, the 2020 denominator data was used because the exact total for 2021 is not yet available.


We have final data for 2020 as follows: Annual Indicator - 10.3; Numerator - 40; Denominator - 388,427.

Missouri Vital Statistics Death File was used as data source.

Data Alerts: None

NOM 17.1 - Percent of children with special health care needs (CSHCN), ages 0 through 17**Data Source: National Survey of Children's Health (NSCH)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	21.1 %	1.4 %	288,780	1,368,395
2018_2019	21.9 %	1.5 %	301,956	1,375,829
2017_2018	21.2 %	1.7 %	293,652	1,382,534
2016_2017	21.5 %	1.6 %	298,327	1,385,801
2016	22.8 %	1.7 %	316,087	1,386,660

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 17.1 - Notes:**

None

Data Alerts: None

NOM 17.2 - Percent of children with special health care needs (CSHCN), ages 0 through 17, who receive care in a well-functioning system

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	19.7 %	2.9 %	56,805	288,780
2018_2019	15.6 %	2.7 %	47,149	301,956
2017_2018	16.4 %	3.3 %	48,147	293,652
2016_2017	19.2 %	3.2 %	57,406	298,327
2016	19.2 %	3.3 %	60,757	316,087

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution


NOM 17.2 - Notes:

None

Data Alerts: None

NOM 17.3 - Percent of children, ages 3 through 17, diagnosed with an autism spectrum disorder**Data Source: National Survey of Children's Health (NSCH)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.1 %	0.5 %	23,725	1,143,480
2018_2019	2.0 %	0.5 %	23,159	1,140,048
2017_2018	2.2 %	0.6 %	25,127	1,136,126
2016_2017	2.7 %	0.6 %	30,948	1,131,436
2016	3.0 %	0.8 %	34,462	1,158,499

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 17.3 - Notes:**

None

Data Alerts: None

NOM 17.4 - Percent of children, ages 3 through 17, diagnosed with Attention Deficit Disorder/Attention Deficit Hyperactivity Disorder (ADD/ADHD)

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	8.4 %	0.9 %	95,578	1,134,465
2018_2019	10.7 %	1.3 %	121,359	1,131,234
2017_2018	11.0 %	1.5 %	125,283	1,134,509
2016_2017	9.8 %	1.2 %	111,315	1,130,732
2016	10.3 %	1.3 %	118,512	1,149,872

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 17.4 - Notes:

None

Data Alerts: None

NOM 18 - Percent of children, ages 3 through 17, with a mental/behavioral condition who receive treatment or counseling

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	48.7 %	4.6 %	74,063	151,975
2018_2019	53.6 %	5.1 %	91,376	170,506
2017_2018	51.9 % ⚡	6.2 % ⚡	87,101 ⚡	167,958 ⚡
2016_2017	57.2 % ⚡	6.0 % ⚡	80,743 ⚡	141,196 ⚡
2016	64.0 % ⚡	6.3 % ⚡	91,752 ⚡	143,344 ⚡

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 18 - Notes:

None

Data Alerts: None

NOM 19 - Percent of children, ages 0 through 17, in excellent or very good health

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	90.6 %	1.2 %	1,229,690	1,357,216
2018_2019	88.5 %	1.3 %	1,214,704	1,371,977
2017_2018	89.8 %	1.3 %	1,239,942	1,380,789
2016_2017	91.0 %	1.2 %	1,257,974	1,382,631
2016	90.8 %	1.4 %	1,252,871	1,380,320

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 19 - Notes:

None

Data Alerts: None

NOM 20 - Percent of children, ages 2 through 4, and adolescents, ages 10 through 17, who are obese (BMI at or above the 95th percentile)

Data Source: WIC

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2018	13.0 %	0.2 %	4,710	36,127
2016	12.3 %	0.2 %	5,335	43,404
2014	13.0 %	0.2 %	5,696	43,895
2012	13.5 %	0.2 %	6,913	51,368
2010	14.4 %	0.2 %	7,306	50,575
2008	14.6 %	0.2 %	6,684	45,662

Legends:

🚩 Indicator has a denominator <50 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: Youth Risk Behavior Surveillance System (YRBSS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	18.4 %	1.7 %	46,328	251,708
2017	16.6 %	1.4 %	42,368	254,814
2015	13.1 %	1.6 %	33,506	256,658
2013	14.9 %	1.3 %	37,631	253,277
2009	14.3 %	1.0 %	37,677	263,540
2007	11.9 %	1.4 %	31,402	264,619
2005	13.8 %	1.2 %	36,083	260,788

Legends:

🚩 Indicator has an unweighted denominator <100 and is not reportable

⚡ Indicator has a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	19.6 %	2.2 %	109,081	557,921
2018_2019	16.3 %	2.0 %	93,473	572,420
2017_2018	12.5 %	1.8 %	73,841	588,818
2016_2017	12.7 %	1.7 %	72,138	568,815
2016	14.0 %	2.2 %	78,884	562,399

Legends:

🚫 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 20 - Notes:

None


Data Alerts: None

NOM 21 - Percent of children, ages 0 through 17, without health insurance

Data Source: American Community Survey (ACS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019	6.4 %	0.4 %	87,028	1,369,358
2018	4.7 %	0.3 %	64,442	1,373,732
2017	4.5 %	0.3 %	62,542	1,385,654
2016	4.7 %	0.3 %	65,048	1,389,424
2015	5.8 %	0.3 %	80,405	1,387,462
2014	6.8 %	0.4 %	94,070	1,392,278
2013	7.3 %	0.5 %	101,597	1,398,774
2012	7.2 %	0.4 %	100,248	1,400,984
2011	6.7 %	0.4 %	94,012	1,410,826
2010	6.3 %	0.4 %	89,775	1,417,025
2009	7.1 %	0.4 %	102,160	1,431,242

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution**NOM 21 - Notes:**

None

Data Alerts: None


NOM 22.1 - Percent of children who have completed the combined 7-vaccine series (4:3:1:3*:3:1:4) by age 24 months


Data Source: National Immunization Survey (NIS)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2017	70.0 %	3.2 %	50,000	72,000
2016	58.3 %	4.4 %	44,000	75,000
2015	68.4 %	4.0 %	52,000	76,000
2014	67.3 %	3.8 %	52,000	77,000
2013	57.8 %	4.7 %	44,000	76,000
2012	68.8 %	4.3 %	52,000	76,000
2011	60.1 %	4.5 %	46,000	76,000

Legends:

 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

 Estimates with 95% confidence interval widths >20 or that are inestimable might not be reliable

NOM 22.1 - Notes:

None

Data Alerts: None

NOM 22.2 - Percent of children, ages 6 months through 17 years, who are vaccinated annually against seasonal influenza

Data Source: National Immunization Survey (NIS) – Flu

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020_2021	58.3 %	1.7 %	755,094	1,295,187
2019_2020	59.7 %	1.6 %	765,203	1,281,747
2018_2019	57.0 %	1.9 %	734,540	1,288,893
2017_2018	50.8 %	1.9 %	663,536	1,306,209
2016_2017	53.9 %	1.7 %	704,687	1,307,883
2015_2016	59.4 %	2.2 %	781,158	1,315,081
2014_2015	54.1 %	1.9 %	712,828	1,318,342
2013_2014	54.0 %	1.9 %	712,235	1,320,284
2012_2013	51.6 %	2.2 %	683,156	1,324,118
2011_2012	44.9 %	2.6 %	600,028	1,336,935
2010_2011	48.1 %	2.8 %	643,683	1,338,218
2009_2010	38.4 %	2.7 %	464,148	1,208,718

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or because the relative standard error is >0.3.

⚡ Estimates with 95% confidence interval half-widths > 10 might not be reliable

NOM 22.2 - Notes:

None

Data Alerts: None

NOM 22.3 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the HPV vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	69.9 %	3.1 %	275,289	393,934
2019	69.0 %	3.5 %	270,385	391,684
2018	61.6 %	3.3 %	240,545	390,439
2017	57.8 %	3.3 %	226,431	391,861
2016	51.6 %	3.4 %	202,093	391,848
2015	51.8 %	3.6 %	204,078	394,099

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable



NOM 22.3 - Notes:

None

Data Alerts: None

NOM 22.4 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the Tdap vaccine**Data Source: National Immunization Survey (NIS) - Teen****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	84.2 %	2.5 %	331,860	393,934
2019	82.4 %	2.8 %	322,624	391,684
2018	80.6 %	2.9 %	314,818	390,439
2017	80.1 %	2.8 %	313,877	391,861
2016	83.9 %	2.4 %	328,587	391,848
2015	85.7 %	2.5 %	337,703	394,099
2014	86.1 %	2.3 %	342,835	398,320
2013	81.5 %	2.8 %	325,358	399,029
2012	88.0 %	2.5 %	352,124	399,970
2011	79.6 %	2.7 %	319,043	400,748
2010	66.0 %	3.0 %	265,563	402,428
2009	60.2 %	2.9 %	244,974	407,293

Legends: Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate > 1.2 Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable**NOM 22.4 - Notes:**

None

Data Alerts: None

NOM 22.5 - Percent of adolescents, ages 13 through 17, who have received at least one dose of the meningococcal conjugate vaccine

Data Source: National Immunization Survey (NIS) - Teen

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	85.3 %	2.4 %	336,135	393,934
2019	84.8 %	2.6 %	331,974	391,684
2018	78.3 %	2.9 %	305,793	390,439
2017	74.3 %	2.9 %	291,109	391,861
2016	66.2 %	3.2 %	259,219	391,848
2015	69.7 %	3.3 %	274,832	394,099
2014	63.3 %	3.3 %	252,165	398,320
2013	60.7 %	3.6 %	242,178	399,029
2012	58.3 %	3.9 %	233,048	399,970
2011	54.6 %	3.3 %	218,744	400,748
2010	49.2 %	3.0 %	197,927	402,428
2009	45.5 %	3.0 %	185,153	407,293

Legends:

🚫 Estimate not reported because unweighted sample size for the denominator < 30 or 95% confidence interval width/estimate >1.2

⚡ Estimates with 95% confidence interval widths > 20 or that are inestimable might not be reliable


NOM 22.5 - Notes:

None

Data Alerts: None

NOM 23 - Teen birth rate, ages 15 through 19, per 1,000 females**Data Source: National Vital Statistics System (NVSS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	18.8	0.3	3,556	189,387
2019	20.3	0.3	3,851	189,903
2018	21.6	0.3	4,109	190,464
2017	22.5	0.3	4,301	191,316
2016	23.4	0.4	4,505	192,808
2015	25.1	0.4	4,838	192,583
2014	27.2	0.4	5,232	192,076
2013	30.0	0.4	5,814	193,780
2012	32.2	0.4	6,317	196,167
2011	34.6	0.4	6,944	200,937
2010	37.3	0.4	7,669	205,841
2009	40.6	0.4	8,499	209,478



Legends: Indicator has a numerator <10 and is not reportable Indicator has a numerator <20 and should be interpreted with caution**NOM 23 - Notes:**

None

Data Alerts: None

NOM 24 - Percent of women who experience postpartum depressive symptoms following a recent live birth**Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)****Multi-Year Trend**

Year	Annual Indicator	Standard Error	Numerator	Denominator
2020	13.3 %	1.3 %	8,617	64,586
2019	14.6 %	1.2 %	9,700	66,257
2018	13.7 %	1.3 %	9,213	67,191
2017	13.9 %	1.2 %	9,371	67,202
2016	14.0 %	1.3 %	9,774	69,686
2015	14.0 %	1.2 %	9,834	70,137
2014	12.6 %	1.1 %	8,948	70,939
2013	12.5 %	1.1 %	8,862	70,850
2012	15.0 %	1.4 %	10,559	70,436

Legends: Indicator has an unweighted denominator <30 and is not reportable Indicator has an unweighted denominator between 30 and 59 or a confidence interval width >20% points or >1.2 times the estimate and should be interpreted with caution**NOM 24 - Notes:**

None

Data Alerts: None

NOM 25 - Percent of children, ages 0 through 17, who were unable to obtain needed health care in the past year

Data Source: National Survey of Children's Health (NSCH)

Multi-Year Trend

Year	Annual Indicator	Standard Error	Numerator	Denominator
2019_2020	2.3 %	0.5 %	31,290	1,363,872
2018_2019	3.3 %	0.7 %	44,823	1,371,360
2017_2018	2.6 %	0.7 %	35,722	1,381,458
2016_2017	2.8 %	0.7 %	38,213	1,376,406
2016	3.7 %	0.9 %	50,741	1,367,870

Legends:

🚩 Indicator has an unweighted denominator <30 and is not reportable

⚡ Indicator has a confidence interval width >20% points, >1.2 times the estimate, or that is inestimable and should be interpreted with caution

NOM 25 - Notes:

None

Data Alerts: None

Form 10
National Performance Measures (NPMs)
State: Missouri

NPM 1 - Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Federally Available Data					
Data Source: Behavioral Risk Factor Surveillance System (BRFSS)					
	2017	2018	2019	2020	2021
Annual Objective				70.1	70.5
Annual Indicator			72.9	72.6	72.5
Numerator			757,602	754,373	755,016
Denominator			1,038,992	1,039,355	1,041,255
Data Source			BRFSS	BRFSS	BRFSS
Data Source Year			2018	2019	2020

i Previous NPM-1 BRFSS data for survey years 2016 and 2017 that was pre-populated under the 2017 and 2018 Annual Report Years is no longer displayed since it is not comparable with 2018 survey data.

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	64.8	66.4	68.1	70.1	70.5
Annual Indicator	66	72.9	72.6	72.5	72.5
Numerator	699,148	769,769	769,579	755,016	755,016
Denominator	1,059,959	1,055,678	1,060,305	1,041,255	1,041,255
Data Source	BRFSS	BRFSS	BRFSS	BRFSS	BRFSS
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	71.0	71.5	72.0	72.9

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note:	2019 data
2.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	2019 data used as proxy for 2020

NPM 5A - Percent of infants placed to sleep on their backs

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			85.2
Annual Indicator	84.0	83.1	84.8
Numerator	55,547	54,118	53,369
Denominator	66,118	65,137	62,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			85.2
Annual Indicator	83.1	84.8	84.8
Numerator	54,118	53,369	53,369
Denominator	65,137	62,925	62,925
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	86.4	87.6	88.8	90.0

Field Level Notes for Form 10 NPMs:

None

NPM 5B - Percent of infants placed to sleep on a separate approved sleep surface

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			41.9
Annual Indicator	39.9	40.3	37.1
Numerator	25,485	25,609	23,096
Denominator	63,920	63,599	62,314
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			41.9
Annual Indicator	40.3	37.1	37.1
Numerator	25,609	23,096	23,096
Denominator	63,599	62,314	62,314
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	43.9	46.0	48.0	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 5C - Percent of infants placed to sleep without soft objects or loose bedding

Federally Available Data			
Data Source: Pregnancy Risk Assessment Monitoring System (PRAMS)			
	2019	2020	2021
Annual Objective			49
Annual Indicator	48.7	55.0	54.6
Numerator	31,408	35,105	33,976
Denominator	64,465	63,808	62,273
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2018	2019	2020

State Provided Data			
	2019	2020	2021
Annual Objective			49
Annual Indicator	55	54.6	54.6
Numerator	35,105	33,976	33,976
Denominator	63,808	62,273	62,273
Data Source	PRAMS	PRAMS	PRAMS
Data Source Year	2019	2020	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	49.2	49.5	49.7	50.0

Field Level Notes for Form 10 NPMs:

None

NPM 7.2 - Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19

Federally Available Data					
Data Source: HCUP - State Inpatient Databases (SID)					
	2017	2018	2019	2020	2021
Annual Objective	262	278.4	275.2	275.1	275
Annual Indicator	291.9	281.6	284.0	271.9	278.6
Numerator	1,718	2,211	2,226	2,130	2,175
Denominator	588,524	785,023	783,928	783,327	780,786
Data Source	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT	SID- ADOLESCENT
Data Source Year	2015	2016	2017	2018	2019

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	262	278.4	275.2	275.1	275
Annual Indicator	275.3	250.2	254.1	275.9	275.9
Numerator	2,158	1,960	1,984	2,148	2,148
Denominator	783,928	783,327	780,786	778,428	778,428
Data Source	MO PAS	MO PAS	MO PAS	MO PAS	MO PAS
Data Source Year	2017	2018	2019	2020	2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	274.9	274.8	274.8	274.7

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: 2019 used as proxy for 2020	

NPM 8.1 - Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Federally Available Data			
Data Source: National Survey of Children's Health (NSCH) - CHILD			
	2019	2020	2021
Annual Objective			37.6
Annual Indicator	37.4	32.8	31.2
Numerator	174,971	156,884	145,507
Denominator	467,457	477,809	465,671
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2017_2018	2018_2019	2019_2020

State Provided Data			
	2019	2020	2021
Annual Objective			37.6
Annual Indicator	32.8	31.2	31.2
Numerator	156,884	145,507	145,507
Denominator	477,809	465,671	465,671
Data Source	NSCH-CHILD	NSCH-CHILD	NSCH-CHILD
Data Source Year	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	37.8	38.2	38.4	38.6

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data

Field Note:
2020-2021 data not available.

NPM 11 - Percent of children with and without special health care needs, ages 0 through 17, who have a medical home - Children with Special Health Care Needs

Federally Available Data					
Data Source: National Survey of Children's Health (NSCH) - CSHCN					
	2017	2018	2019	2020	2021
Annual Objective		43.5	49	49.8	50.6
Annual Indicator	42.7	48.6	50.6	46.9	51.9
Numerator	134,875	144,848	148,654	141,727	149,881
Denominator	316,087	298,327	293,652	301,956	288,780
Data Source	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN	NSCH-CSHCN
Data Source Year	2016	2016_2017	2017_2018	2018_2019	2019_2020

State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective		43.5	49	49.8	50.6
Annual Indicator	48.6	50.6	46.9	51.9	51.9
Numerator	144,848	148,654	141,727	149,881	149,881
Denominator	298,326	293,652	301,956	288,780	288,780
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	51.4	52.2	53.0	54.0

Field Level Notes for Form 10 NPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note: 2020-2021 data not available.	

Form 10
State Performance Measures (SPMs)

State: Missouri

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Measure Status:					Active
State Provided Data					
	2017	2018	2019	2020	2021
Annual Objective	73	71.5	71.7	71.9	72.1
Annual Indicator	70.4	70.9	74.2	72.5	72.5
Numerator	909,454	923,366	955,152	928,942	928,942
Denominator	1,291,860	1,302,509	1,288,116	1,280,625	1,280,625
Data Source	NSCH	NSCH	NSCH	NSCH	NSCH
Data Source Year	2016_2017	2017_2018	2018_2019	2019_2020	2019_2020
Provisional or Final ?	Final	Final	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	72.3	72.5	72.7	72.9

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2017
	Column Name:	State Provided Data
	Field Note: Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH)	
2.	Field Name:	2018
	Column Name:	State Provided Data
	Field Note: Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH)	
3.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note: Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH)	
4.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: Note: Annual objectives based on percent of children, ages 01 to 17 years, who had a preventive dental visit in the last year. Data Source: National Survey of Children's Health (NSCH)	
5.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note: 2020-2021 data not available	

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			17.4
Annual Indicator	17.4		17.4
Numerator	1,200		1,200
Denominator	6,897		6,897
Data Source	YRBS		YRBS
Data Source Year	2019		2019
Provisional or Final ?	Final		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	16.8	16.2	15.5	15.0

Field Level Notes for Form 10 SPMs:

1.	Field Name:	2021
	Column Name:	State Provided Data
	Field Note:	2021 data not yet available for release

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			20
Annual Indicator	0		48
Numerator			
Denominator			
Data Source	MO DHSS MCH Program training attendance sheets		MO DHSS Internal Survey
Data Source Year	2019		2021
Provisional or Final ?	Provisional		Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	100.0	150.0	175.0	200.0

Field Level Notes for Form 10 SPMs:

None

Form 10
Evidence-Based or –Informed Strategy Measures (ESMs)

State: Missouri

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			85.8
Annual Indicator	85.3	83.7	86.7
Numerator	604	1,001	1,204
Denominator	708	1,196	1,388
Data Source	BRFSS	BRFSS	BRFSS
Data Source Year	2018	2019	2020
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	86.2	86.8	87.2	87.9

Field Level Notes for Form 10 ESMs:

None

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			83.6
Annual Indicator	83.3	91.8	76.6
Numerator	234	202	108
Denominator	281	220	141
Data Source	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program	MO DHSS Safe Cribs Program
Data Source Year	2019	2020	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	83.8	84.0	84.6	85.0

Field Level Notes for Form 10 ESMs:

None

ESM 7.2.1 - Percentage of high school students who reported distracted driving.

Measure Status:			Active
State Provided Data			
	2019	2020	2021
Annual Objective			45
Annual Indicator	45.8	45.8	45.8
Numerator	722	722	722
Denominator	1,576	1,576	1,576
Data Source	YRBSS	YRBSS	YRBSS
Data Source Year	2019	2019	2019
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	44.2	43.5	42.5	41.5

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note:	2019 YRBSS data used as proxy for 2020 year

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			50
Annual Indicator	33	33	352
Numerator			
Denominator			
Data Source	MO DHSS Go NAPSACC data	MO DHSS Go NAPSACC data	MOPHIRS Report -CLPHS Service Log
Data Source Year	2019	2019	2021
Provisional or Final ?	Final	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	100.0	200.0	300.0	400.0

Field Level Notes for Form 10 ESMs:

None

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

Measure Status:		Active	
State Provided Data			
	2019	2020	2021
Annual Objective			1,800
Annual Indicator	1,682	1,822	1,057
Numerator			
Denominator			
Data Source	MO DHSS Programs	MO DHSS Programs	MO DHSS Programs
Data Source Year	2019	2020	2021
Provisional or Final ?	Provisional	Final	Final

Annual Objectives				
	2022	2023	2024	2025
Annual Objective	2,000.0	2,400.0	2,800.0	3,000.0

Field Level Notes for Form 10 ESMs:

1.	Field Name:	2019
	Column Name:	State Provided Data
	Field Note: Family Partnership will disseminate information on the importance of a medical home to families of children and youth with special health care needs. Family Partnership previously shared a newsletter focusing on medical home information with families enrolled in SHCN services.	
2.	Field Name:	2020
	Column Name:	State Provided Data
	Field Note: Family Partnership will disseminate information on the importance of a medical home to families of children and youth with special health care needs. Family Partnership previously shared a newsletter focusing on medical home information with families enrolled in SHCN services.	

Form 10
State Performance Measure (SPM) Detail Sheets

State: Missouri

SPM 1 - Percent of children, ages 1 to 17 years, who had a preventive dental visit in the last year.

Population Domain(s) – Child Health

Measure Status:	Active	
Goal:	To increase the number of children, ages 1-17 years, who had a preventive dental visit in the last year.	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Children, ages 1-17, who had a preventive dental visit in the last year.
	Denominator:	All children ages 1 through 17 years.
Data Sources and Data Issues:	National Survey of Children's Health (NSCH)	
Significance:	<p>Poor oral health in children is linked to difficulty speaking, eating, and learning. Poor oral health is linked to poor overall health for children and adults both.</p> <p>Preventive dental visits are recommended for pregnant women due to increased risk of periodontal disease during pregnancy. Poor oral health during pregnancy is dangerous for the mother and is linked to poor outcomes for infants.</p>	
	<p>Preventive dental visits are recommended at least annually for infants and children.</p> <p>Preventive dental visits include a cleaning and examination for tooth decay and other issues with the teeth, gums, and jaw. Many dental visits also result in the application of fluoride varnish and/or dental sealants on molars to prevent dental caries.</p>	
	<p>For both children and adults, dental visits are an important time for providing education about proper oral hygiene, prevention of dental injuries, and importance of good oral health for overall health.</p>	

SPM 2 - Suicide and self-harm rate among youth ages 10 through 19
Population Domain(s) – Adolescent Health

Measure Status:	Active									
Goal:	By 2025, reduce the suicide death rate among youths 10-19 years from 7.8% per 100,000 (CY 2019 Vital Statistics).									
Definition:	<table><tr><td>Unit Type:</td><td>Percentage</td></tr><tr><td>Unit Number:</td><td>100</td></tr><tr><td>Numerator:</td><td>Number of high school kids who seriously considered attempting suicide in the past year (YRBS)</td></tr><tr><td>Denominator:</td><td>Number of adolescents in grades 9 through 12 (YRBS)</td></tr></table>		Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of high school kids who seriously considered attempting suicide in the past year (YRBS)	Denominator:	Number of adolescents in grades 9 through 12 (YRBS)
Unit Type:	Percentage									
Unit Number:	100									
Numerator:	Number of high school kids who seriously considered attempting suicide in the past year (YRBS)									
Denominator:	Number of adolescents in grades 9 through 12 (YRBS)									
Data Sources and Data Issues:	YRBS									
Significance:	According to 2019 (Provisional) Missouri Vital Statistics provisional data, suicide remains the tenth leading cause of death for all ages among Missouri residents and the third leading cause of death among adolescents 10-19 years old. In 2019, there were 61 deaths due to suicide among adolescents ages 10 to 19 years, or 7.8 deaths per 100,000. Suicide and suicidal ideation is often indicative of mental health problems and stressful or traumatic life events. In 2019, 17.4 percent of high school students reported they had thought seriously about committing suicide in the past year. While females are more likely to report considering suicide, males are more likely to succeed in committing suicide. The suicide mortality rate for males is nearly four times that of females in adolescent age group.									

SPM 3 - Number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.

Population Domain(s) – Cross-Cutting/Systems Building

Measure Status:	Active	
Goal:	Increase the number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.	
Definition:	Unit Type:	Count
	Unit Number:	10,000
	Numerator:	The number of DCPH staff and contracted partners working with maternal and child populations who complete core MCH, Health Equity, and Racial Justice trainings.
	Denominator:	
Data Sources and Data Issues:	MO DHSS MCH Program training attendance sheets	
Significance:	Increasing staff awareness through training, and providing opportunities to deepen their practical knowledge of applying an equity lens to their work, will be valuable infrastructure-building activities that have the potential to impact MCH work across the state. The state Title V program will promote training resources on health equity, and racial justice concepts to staff members. Partners who had better understand principles related to health equity, social determinants of health, the life course model, and other relevant frameworks, would be better able to incorporate these principles into their programs and the community.	

Form 10
State Outcome Measure (SOM) Detail Sheets
State: Missouri

No State Outcome Measures were created by the State.

Form 10
Evidence-Based or –Informed Strategy Measures (ESM) Detail Sheets

State: Missouri

ESM 1.1 - Percent of women who reported a routine checkup within past 2 years (BRFSS).

NPM 1 – Percent of women, ages 18 through 44, with a preventive medical visit in the past year

Measure Status:	Active								
Goal:	Increase the percent of women who reported a routine checkup within past 2 years (BRFSS).								
Definition:	<table border="1"> <tr> <td>Unit Type:</td><td>Percentage</td></tr> <tr> <td>Unit Number:</td><td>100</td></tr> <tr> <td>Numerator:</td><td>Number of women, ages 18 through 44, who had a preventive medical visit within past 2 years</td></tr> <tr> <td>Denominator:</td><td>Number of women, ages 18 through 44</td></tr> </table>	Unit Type:	Percentage	Unit Number:	100	Numerator:	Number of women, ages 18 through 44, who had a preventive medical visit within past 2 years	Denominator:	Number of women, ages 18 through 44
Unit Type:	Percentage								
Unit Number:	100								
Numerator:	Number of women, ages 18 through 44, who had a preventive medical visit within past 2 years								
Denominator:	Number of women, ages 18 through 44								
Data Sources and Data Issues:	BRFSS								
Significance:	A well-woman or preconception visit provides a critical opportunity to receive recommended clinical preventive services, including screening, counseling, and immunizations, which can lead to appropriate identification, treatment, and prevention of disease to optimize the health of women before, between, and beyond potential pregnancies. For example, screening and management of chronic conditions such as diabetes, and counseling to achieve a healthy weight and smoking cessation, can be advanced within a well woman visit to promote women's health prior to and between pregnancies and improve subsequent maternal and perinatal outcomes.								

ESM 5.1 - At the time of follow-up, percent of safe crib program clients who were placing their baby in a safe sleep environment.

NPM 5 – A) Percent of infants placed to sleep on their backs B) Percent of infants placed to sleep on a separate approved sleep surface C) Percent of infants placed to sleep without soft objects or loose bedding

Measure Status:	Active	
Goal:	Increase the percent of safe crib program clients who were placing their baby in a safe sleep environment.	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	At the time of follow-up, number of mothers reporting that they most often place their baby in a safe sleep environment
	Denominator:	Number of Safe crib program clients participated in follow-up visit
Data Sources and Data Issues:	MO DHSS Safe Cribs Program	
Significance:	<p>Sleep-related infant deaths, also called Sudden Unexpected Infant Deaths (SUID), are the leading cause of infant death after the first month of life and the third leading cause of infant death overall. Sleep-related SUIDs include Sudden Infant Death Syndrome (SIDS), unknown cause, and accidental suffocation and strangulation in bed. Due to heightened risk of SIDS when infants are placed to sleep in side (lateral) or stomach (prone) sleep positions, the American Academy of Pediatrics (AAP) has long recommended the back (supine) sleep position. In 2011, AAP expanded its recommendations to help reduce the risk of all sleep-related deaths through a safe sleep environment that includes use of the back-sleep position, on a separate firm sleep surface (room-sharing without bed sharing), and without loose bedding. http://pediatrics.aappublications.org/content/128/5/1030</p>	

ESM 7.2.1 - Percentage of high school students who reported distracted driving.**NPM 7.2 – Rate of hospitalization for non-fatal injury per 100,000 adolescents, ages 10 through 19**

Measure Status:	Active	
Goal:	Decrease the high school students who reported distracted driving	
Definition:	Unit Type:	Percentage
	Unit Number:	100
	Numerator:	Number of students who texted or e-mailed while driving a car or other vehicle (on at least 1 day during the 30 days before the survey, among students who had driven a car or other vehicle during the 30 days before the survey)
	Denominator:	Number of adolescents in grades ages 9 through 12
Data Sources and Data Issues:	YRBS	
Significance:	<p>Motor-vehicle crashes are a leading cause of death and nonfatal injury among Missouri adolescents, resulting in approximately 75 deaths and 2,000 nonfatal injuries each year. Risk for motor-vehicle crashes and resulting injuries and deaths varies, depending on such behaviors as seat belt use or impaired or distracted driving. Improved understanding of adolescents' transportation risk behaviors can guide prevention efforts. According to the Missouri 2019 Youth Risk Behavior Survey approximately 8.5% of high school students did not always wear a seat belt, 15.8% rode with a drinking driver, 4.2% of students had driven a car after drinking alcohol and 45.8% had texted or e-mailed while driving during the 30 days before the survey. Traffic safety and public health professionals can use these findings to reduce transportation risk behaviors by selecting, implementing, and contextualizing the most appropriate and effective strategies for specific populations and for the environment.</p>	

ESM 8.1.1 - Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.

NPM 8.1 – Percent of children, ages 6 through 11, who are physically active at least 60 minutes per day

Measure Status:	Active	
Goal:	Increase the number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.	
Definition:	Unit Type:	Count
	Unit Number:	5,000
	Numerator:	Number of programs/training's on promoting healthy eating and active lifestyle campaigns among children.
	Denominator:	
Data Sources and Data Issues:	MO DHSS Go NAPSACC data	
Significance:	Increasing awareness and knowledge about the importance of proper nutrition and the consequences of poor nutritional habits is a first step for good health practices. Developing skills for reading food labels and preparing healthy snacks and meals are important for improving nutritional behaviors. Creating social support networks to encourage adoption of healthy nutritional habits can be accomplished through community cooking classes, dinner clubs, and offering healthy party snacks. Child Care Wellness contracts will support LPHAs in providing training and technical assistance to child care providers in improving child care physical activity and nutrition policies and practices. LPHAs will use the University of North Carolina's Go NAPSACC online system to assist and track child care providers' progress.	

ESM 11.1 - Number of family members, healthcare providers, and community professionals who receive education on the medical home approach.

NPM 11 – Percent of children with and without special health care needs, ages 0 through 17, who have a medical home

Measure Status:	Active									
Goal:	Increase the number of family members, healthcare providers, and community professionals educated on the medical home approach									
Definition:	<table><tr><td>Unit Type:</td><td>Count</td></tr><tr><td>Unit Number:</td><td>10,000</td></tr><tr><td>Numerator:</td><td>Number of family members, healthcare providers, and community professionals who receive education on the medical home approach</td></tr><tr><td>Denominator:</td><td></td></tr></table>		Unit Type:	Count	Unit Number:	10,000	Numerator:	Number of family members, healthcare providers, and community professionals who receive education on the medical home approach	Denominator:	
Unit Type:	Count									
Unit Number:	10,000									
Numerator:	Number of family members, healthcare providers, and community professionals who receive education on the medical home approach									
Denominator:										
Data Sources and Data Issues:	MO DHSS program data									
Significance:	<p>The American Academy of Pediatrics (AAP) specifies seven qualities essential to medical home care, which include accessible, family-centered, continuous, comprehensive, coordinated, compassionate and culturally effective. Providing comprehensive and coordinated care to children in a medical home is the standard of pediatric practice. Research indicates that children with a stable and continuous source of health care are more likely to receive appropriate preventive care, are less likely to be hospitalized for preventable conditions, and are more likely to be diagnosed early for chronic or disabling conditions. The Maternal and Child Health Bureau uses the AAP definition of medical home. https://medicalhomeinfo.aap.org/Pages/default.aspx</p>									

Form 11
Other State Data

State: Missouri

The Form 11 data are available for review via the link below.

[Form 11 Data](#)

Form 12
MCH Data Access and Linkages

State: Missouri

Annual Report Year 2021

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
1) Vital Records Birth	Yes	Yes	Daily	1		
2) Vital Records Death	Yes	Yes	Daily	1	Yes	
3) Medicaid	Yes	Yes	Daily	1	Yes	
4) WIC	Yes	Yes	Daily	1	Yes	
5) Newborn Bloodspot Screening	Yes	Yes	Daily	0	Yes	
6) Newborn Hearing Screening	Yes	Yes	Daily	1	Yes	
7) Hospital Discharge	Yes	Yes	Quarterly	3	Yes	
8) PRAMS or PRAMS-like	Yes	Yes	Annually	24	Yes	

Other Data Source(s) (Optional)

Data Sources	Access				Linkages	
	(A) State Title V Program has Consistent Annual Access to Data Source	(B) State Title V Program has Access to an Electronic Data Source	(C) Describe Periodicity	(D) Indicate Lag Length for Most Timely Data Available in Number of Months	(E) Data Source is Linked to Vital Records Birth	(F) Data Source is Linked to Another Data Source
9) SET-NET	Yes	Yes	Quarterly	1	Yes	

Form Notes for Form 12:

None

Field Level Notes for Form 12:

None